Volume 63, Number 4 Fall 2012 $4.95

Sonoma Medicine

The magazine of the Sonoma County Medical Association

INTERVIEW

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Pain and Suffering

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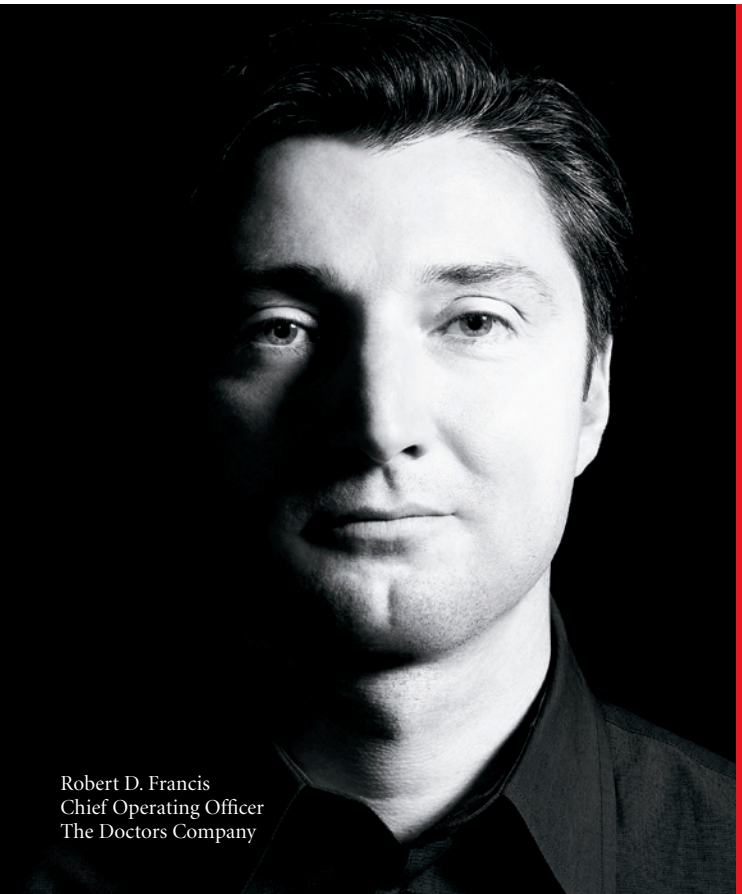

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Sonoma Medicine (ISSN 1534-5386) is the official quarterly magazine of the Sonoma County Medical Association, 2901 Cleveland Ave., Suite 202, Santa Rosa, CA 95403. Periodicals postage paid at Santa Rosa, CA.

POSTMASTER: Send address changes to *Sonoma Medicine,* 2901 Cleveland Ave., Suite 202, Santa Rosa, CA 95403.

Opinions expressed by authors are their own, and not necessarily those of *Sonoma Medicine* or the medical association. The magazine reserves the right to edit or withhold advertisements. Publication of an ad does not represent endorsement by the medical association.

The subscription rate is $19.80 per year (four quarterly issues). For advertising rates and information, contact Erika Goodwin at 707-548-6491 or erika@scma.org.

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Pain and Suffering

Allan Bernstein, MD

Pain is an essential part of our survival mechanism. It warns us that we stepped on a nail or that the coffee is too hot. It triggers autonomic responses that adjust our blood pressure, heart rate, pupillary reactions, blood sugar and blood cortisol levels. It is a warning to get our hand away from the flame and that our shoe is too tight. Pain is something we learn from. We'd like to avoid it, but we need it.

Pain typically indicates injury or potential injury, starting with tissue damage, releasing cytokines, stimulating peripheral nerves, and progressing proximally through nerve roots, spinal cord and into the brain. Spinal reflexes to pain allow us to pull our hand away from a painful stimulus before it even registers in our brain. A series of on/off switches along the way, particularly in the spinal cord and brainstem, allow us to modulate the pain and interpret the meaning. The endpoint, after multiple connections, is the frontal cortex, where we can localize the pain and decide how significant it is.

There are learned behaviors in our reaction to pain and genetic differences as to how we rate pain. "Big boys don't cry" and "crybaby" are terms used in some cultures but not others. When I was studying painful neuropathy, using a 100-point pain scale, some subjects rated their pain at 80 while others claimed 20 for what appeared (to me) to be similar pain. After treatment, the 80s went to 70 and the 20s went to 17, a statistically identical percentage of reduction. Did one group feel more pain, or were they culturally sensitive when describing pain?

Dr. Bernstein, a Sebastopol neurologist, serves on the SCMA Editorial Board.

Anticipating pain will activate pain receptors and the appropriate autonomic responses. In contrast, anticipating pain relief will reduce pain signals, at least transiently. Nocebo responses (expecting something bad to happen) and placebo responses (expecting and getting benefit no matter what the treatment) may confound our research studies, but they can be turned into powerful clinical tools. The 45% placebo response in pain research tells us how much anticipation of relief affects our perception of pain.

The brain can create pain that isn't there, such as phantom limb pain, and override significant pain when circumstances are appropriate, such as war injuries. Chronic pain—pain that persists in spite of no new tissue damage—represents a failure of the normal system that modulates pain.

Suffering is an individual's emotional response to pain. It is not related to the intensity of the pain, but rather to fear, frustration and lack of understanding as to the meaning of the pain. If the etiology of the pain is well understood, one can rationalize severe pain as due to a specific injury, with an anticipated endpoint. Comprehension may not reduce pain, but it can moderate suffering for many people. The language we use to describe unpleasant situations often hints at a lack of control. We "suffer in silence," "suffer the consequences" and "suffer the loss of a loved one." These situations do not describe physiologic pain, but the emotional part of the pain—suffering—is the prominent feature that appears out of our control.

Both pain and suffering are difficult to measure. Pain fibers can be monitored in experimental animals. We assume pain is present when autonomic features appear in correspondence to the level of electrical impulses along pain pathways. We can measure endorphins and serotonin in spinal fluid. While both increase in response to acute pain, they both go down in chronic pain. As we gradually lose our ability to modulate pain, our suffering rises. Raising the level of endorphins and serotonin—through medications, spinal stimulators, exercise, cognitive therapy and diets—may improve pain control and relieve suffering. Therapies such as music, dance, painting and other pleasurable activities also reduce pain and suffering. Dopamine stimulation appears to be the physiologic pathway.

Our compassion for our patients can be a two-edged sword. We treat pain aggressively, often with powerful medications, only to have those medications become less effective, overused and diverted. A better therapeutic tool, time with our patients, is often in short supply. Using group visits and behavior modification programs, teaching proper use of medication, and involving a team of professionals may allow us to combine our talents to achieve the best outcomes in these complex patients. ◇

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New Approaches for Managing Chronic Pain

Michael Yang, MD

Chronic pain affects more than 100 million Americans—more than the combined total of those who suffer from diabetes, heart disease or cancer. The annual cost of pain in the United States ranges from $560 billion to $635 billion, including both the medical costs of pain care and the economic costs related to disability days and lost wages and productivity. The scope of chronic pain management is sometimes confusing and always amorphous. Because pain is subjective, defining and quantifying the severity of a patient's pain is difficult. Nonetheless, there are new armaments to use in our battle against this difficult condition.

As an interventional pain specialist, I use a variety of new techniques to target areas of pain, including epidural steroid injections, facet nerve blocks, radiofrequency rhizotomies, and intercostal nerve blocks. I also use intrathecal pumps that administer medications directly into the spinal canal, in the cerebral spinal fluid. Newer techniques for "compounding" the medications used in these pumps capitalize on the synergistic effects of the various drugs, which may include a local anesthetic, an opioid and an alpha agonist. Ziconotide has also been found to be particularly useful in patients who have developed opioid hypersensitivity (hyperalgesia). I use a combination of up to three types of drugs to achieve the desired pain reduction while minimizing the actual dose of each individual drug, thus reducing the chance of the patient developing a granuloma at the tip of the pump catheter.

Dr. Yang is a pain medicine specialist and anesthesiologist in Santa Rosa.

I also use spinal cord stimulators. These allow me to place electrodes directly on the spinal cord, in the epidural space, where they modulate pain signals that are traveling up the spinal column. Depending on the positioning of the electrodes, I can zero-in on the area of pain and use the stimulation to "cover up" the pain signal. Newer approaches to the use and placement of stimulator leads have made this modality useful in treating even some of the more remote pains. In peripheral neurostimulation, for example, the electrodes are placed in the periphery.

Spinal cord stimulators can be used to treat not only the typical neuropathic and radicular pains, but also classic difficult-to-treat pains, such as chronic headache or migraine, non-malignant pancreatitis or abdominal pain, sacrococcygeal pain, rectal pain, post-thoracotomy pain, post-herpetic neuralgia, diabetic polyneuropathy, and phantom limb pain. The ease of placement of the leads and the "trial" run prior to permanent implant ensure a high success rate for patients who opt to have a permanent stimulator implant.

Aside from the above interventions, I also manage medications. With the rise of prescription drug abuse, medication management has come under increasing scrutiny by the Drug Enforcement Agency. The following statistics suggest the extent of the problem:

- Prescription drug abuse is the second most common abuse in the United States, just behind marijuana.
- Of the top 10 drugs used non-medically by 12th graders, six are pharmaceutical drugs.
- Between 1998 and 2008, the incidence of pain reliever abuse increased more than 400% among people older than 12.
- In 2009, the number of first-time, non-medical users of psychotherapeutics (prescription opioid pain relievers, tranquilizers, sedatives and stimulants) was about the same as the number of first-time marijuana users.

Despite these sobering facts, opioids remain the mainstay of medication management for pain. One of the newer medications that I like to use is a Schedule III opioid (buprenorphine) in transdermal patch form (BuTrans). Buprenorphine is a mu-opioid receptor partial agonist and a kappa-opioid receptor antagonist. Because of its partial agonist property, buprenorphine theoretically has a lower level of manifest physical dependence. The patch's seven-day transdermal delivery system allows for smooth and prolonged pain-control. Because buprenorphine is metabolized

exclusively by the liver, I use it freely in patients with renal failure. It is also the only medication that is a long-acting opioid but still only a Schedule III drug.

Some new pain medications use serotonin and/or norepinephrine reuptake inhibition. One drug in particular, tapentadol (Nucynta), has two mechanisms of action: an opioid receptor agonist and a norepinephrine reuptake inhibitor. Because tapentadol has a multifaceted mechanism of action, its side effects profile is better than those of other pure opioid receptor agonists such as hydrocodone, oxycodone or meperidine. Its use is also made easier because it has two formulations: extended release (for long-acting pain control) and immediate release (for breakthrough control).

Aside from the newer oral medications, I have found topical adjuvants helpful for controlling pain. Lidoderm and Flector patches have been around for years, but I find that compounding a concoction of my own seems to target the exact etiology of the pain much more efficiently. For compounding, I would recommend a pharmacy accredited by the Pharmacy Compounding Association Board that is able to compound a variety of medications into an easily absorbable cream. I use ketamine (a powerful, non-opioid analgesic with noncompetitive NMDA receptor antagonist properties), gabapentin (mechanism of action is unknown but is great for neuropathic pain), flurbiprofen (an NSAID), cyclobenzaprine (muscle relaxant) and two local anesthetics (lidocaine and prilocaine). The reason for using these two local anesthetics is that recent research has found that they have synergistic effects with each other.

Many of my patients have major depression, anxiety and sleep disorders. Though I do not treat the psychiatric disorders, I have found that a new formulation of an old drug is particularly helpful for middle-of-the-night awakenings and pain-induced insomnia. The old drug, zolpidem (Ambien), has a new sublingual tablet formulation called Intermezzo, which has a much shorter duration of action than Ambien. Intermezzo is meant for a sleep period of four hours, as compared to eight hours for Ambien. I find Intermezzo useful for patients who don't have a problem with falling asleep, but rather with staying asleep. Because Intermezzo is the same compound as Ambien, they both have the same side effects profile.

Pain is an amorphous and subjective condition that requires a multimodal approach. Interventional procedures and medication management are the main focus of my practice, but I refer almost all my patients to other specialists so that we can work together as a team to provide optimal pain relief. More and more, physicians are realizing that chronic pain not only takes a toll physically, but also mentally, emotionally and socioeconomically. I find that the treatment of chronic pain is incomplete without a team of physicians, physical therapists, cognitive-behavioral therapists, acupuncturists and chiropractors. I also believe strongly in relaxation therapy, along with yoga and Pilates workouts, to help facilitate the patient's path to a fruitful life.

Managing chronic pain is one of the biggest challenges that we face in our healthcare system and also, inevitably, in our personal lives. Many of us will suffer from pain at some point, and each of us probably knows at least one other person who suffers from chronic pain. I look forward to continuing my work in a field of medicine that is constantly evolving and improving as we search for more effective and comprehensive treatments. ◇

Disclaimer: I do not hold stocks or investments in any of the companies that manufacture the medications or devices mentioned above. I am not reimbursed or paid in any way for writing about these medications or devices. My statements about these medications or devices are based only on my practice and experience.

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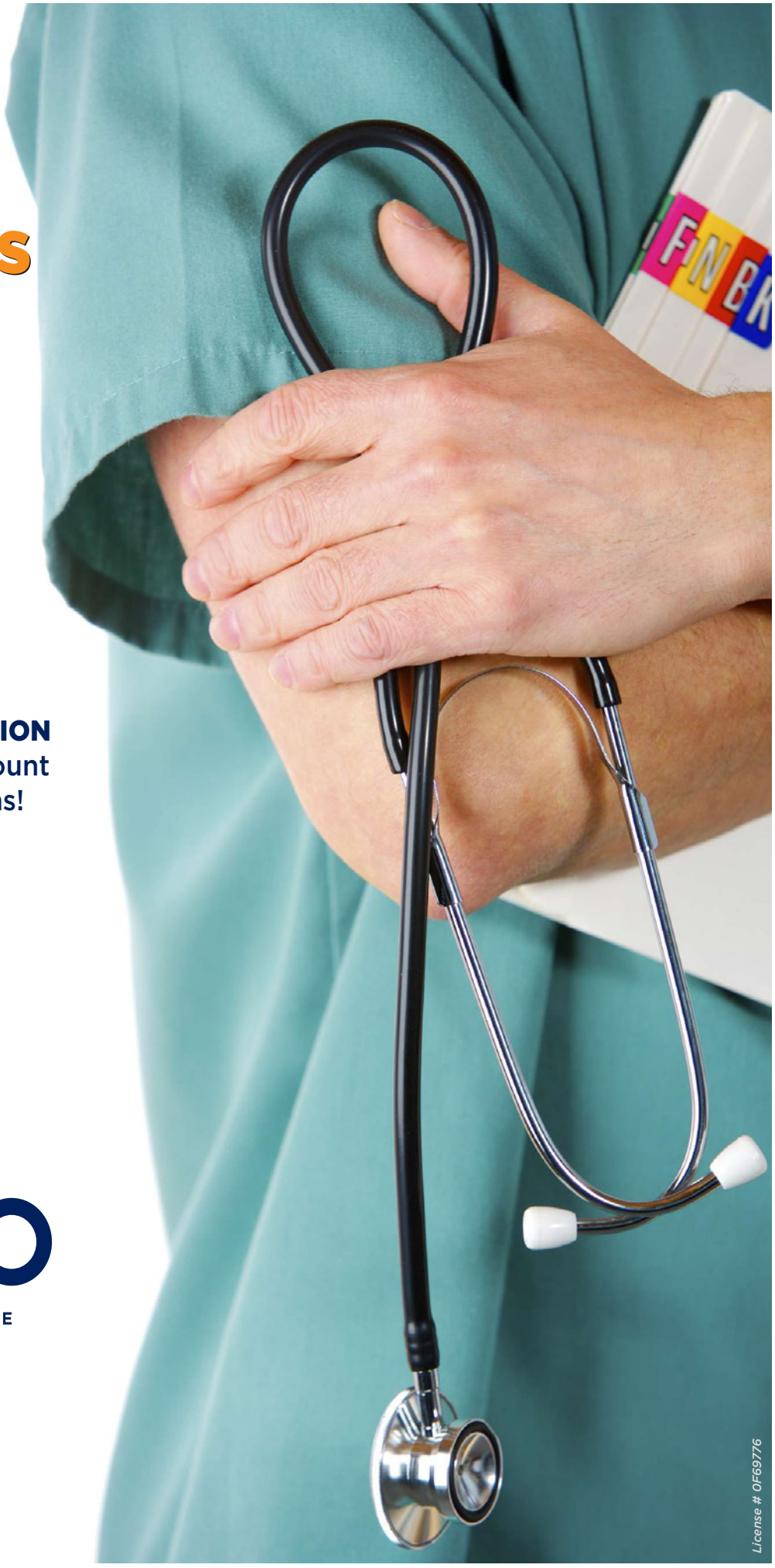

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Can suffering be alleviated?

Andrea Rubinstein, MD

Pain is as diverse as man. One suffers as one can.

—Victor Hugo

Patients want relief from suffering. Doctors by contrast, trained in anatomy and physiology, desperately attempt to treat physical pain. But as anyone who has been on this planet long enough to have their heart broken can attest, not all suffering is physical, and not all physical pain is suffering. Herein lies the clinical conundrum, and perhaps an explanation for why so many doctors dread seeing and treating patients with what is often debilitating pain.

Dr. Eric Cassell, the most oft-quoted physician on the subject of pain and suffering, makes this exact point: "The obligation of physicians to relieve human suffering stretches back to antiquity. Despite this fact, little attention is explicitly given to the problem of suffering in medical education, research or practice."[1]

Allopathic medicine lives in a world of Cartesian dualism that sees mind and body as two distinct, separate entities. We physicians, perhaps with the exception of psychiatrists, consider our domain to be the body, and we prefer to leave the mind, soul and spirit to the poets, philosophers and priests. To a great extent, this approach works. But in the area of pain, and especially in the area of chronic pain, I feel the need to borrow from Dr. Phil and ask, "How's that workin' for ya?" I think the answer generally is "Not well," as witnessed by last year's report from the Institute of Medicine that over 100 million Americans live in pain and that one-third of all visits to primary care doctors involve seeking treatment for pain, either acute or chronic.[2]

Dr. Rubinstein is an anesthesiologist at Kaiser Santa Rosa who specializes in chronic pain.

We give our patients pills and injections for pain, we implant devices for pain, and we perform surgeries for pain. But as many of us who treat these patients can attest, sometimes no matter the intervention or treatment, the patient does not "get better." So we increase the dose and try more interventions, but still the patient says, "Doc, I hurt." Perhaps what they are trying to say is, "Doc, I'm suffering."

Is this a chicken-and-egg debate? Are our patients suffering simply because of their pain? Or are they experiencing their pain amplified through the lens of suffering? Where is the distinction between pain and suffering? Should we refocus our energies with the aim of addressing not just our patients' pain, but also their suffering?

Cassell makes a subtle but powerful point that in order to cause suffering, a situation "must influence the person's perception of future events."[1] For example, if you knew without doubt that your pain would end in five minutes and you would emerge unharmed, you would still be in pain; but your suffering and your fear of becoming overwhelmed and damaged would doubtless dissipate.

I am reminded of a woman with chest pain whom I saw in the emergency room early in my training. She was frightened, and I think suffering greatly, with what she described as "an elephant sitting on her chest." The ER staff ran her through the standard chest pain protocol. Everything was normal. The moment the woman was reassured that she was not having a heart attack, she changed. She continued to complain of pain, but with a very different demeanor. Her suffering had been about her fear, her worries about her own mortality, her body betraying her, and perhaps a myriad of other things. When the future was made clear to her—at least with respect to her not facing imminent demise—she experienced the pain in a completely different and much more tolerable way.

Perhaps within this story is a key to relieving the suffering of our patients. They need to know the future. They need to have their fear alleviated. Fear is always in the future, and fear is the seed of suffering.

When a mother kisses the skinned knee of a toddler and coos, "There, there, it will be all right, kisses will

make it better," her cooing does not change the pain—but the comfort, love and reassurance from this most important person imbues that kiss with a special power to stop the tears almost instantly. In that kiss, the child knows there is nothing to fear, and this knowing that the future will be all right alleviates the suffering and the tears.

Physicians are not prophets. But we have been down these roads with other patients, and we can often honestly tell them what is likely for them. Do we remember to offer hope and reassurance to our suffering patients? Can we map out for them a piece of the future in honest terms that can decrease their fear, even in the face of a disease we cannot cure?

It is interesting to note that chronic pain patients rate their alienation from their physician as being qualitatively worse than their alienation from their loved ones.[3,4] Perhaps this alienation is a result of our longstanding focus on pain relief and our lack of focus on alleviating our patients' suffering.

I recently asked a group of guests at a dinner party, "When was the last time a doctor told you that everything would be all right?" The guests ranged in age from 20 to 80. The older ones smiled, remembering a time when doctors wore starched white coats and offered such reassurances. In contrast, the younger guests looked askance, and one replied, "Who would believe that?"

Have we abdicated this most powerful healing tool, the alleviation of fear? Are our medico-legal concerns so great that we feel we can't risk telling a patient that everything will be fine in case it is not? Or do we not even believe this anymore? Have our relationships with our patients changed so fundamentally that now we are just "partners in health," and no longer healers?

Perhaps one day soon there will be a pill for suffering. In fact, I recently read a paper on daily use of acetaminophen (Tylenol) for reducing pain from social rejection—a suffering if there ever was one.[5] One day soon, relieving suffering may be as simple as saying, "Take two Tylenol and call me in the morning." But for now, we need to delve into that sticky uncomfortable domain of poets, philosophers and priests and remember that in order to treat our patients in pain, we need to address their suffering. Our treatment can start with something as simple as reassurance that everything is going to be all right. ◇

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References

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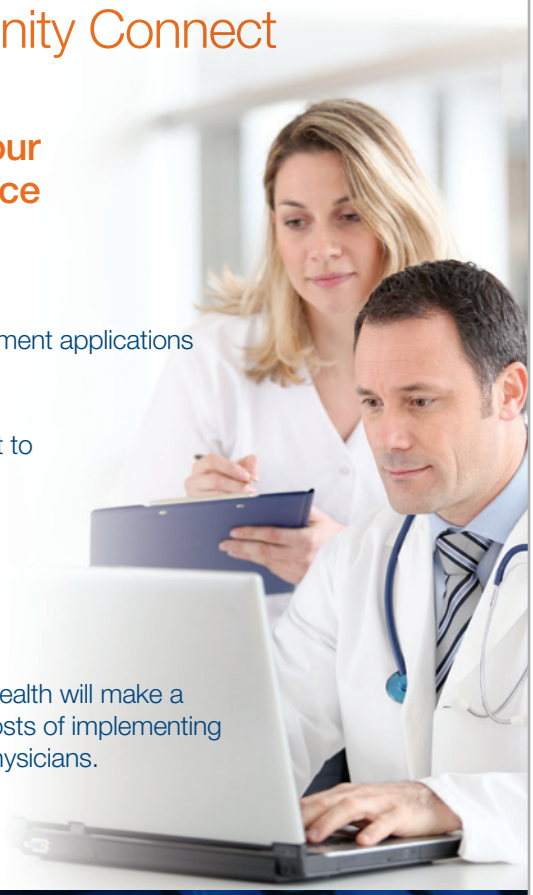

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LATINO HEALTH FORUM

October 11, 2012
7:30 AM - 4:45 PM

FLAMINGO CONFERENCE RESORT & SPA
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Committee Members:

Enrique González-Mendez, MD
Santa Rosa Family Medicine Residency
Mary Puttmann, MD, - *SR Family Medicine Residency*
Christine Hancock - *SR Family Medicine Residency*
Katya Adachi - *SR Family Medicine Residency*
Parker Duncan, MD, MPH - *SR Family Medicine Residency*
Kim Caldewey - *Sonoma County Public Health*
Shan Magnuson - *Kaiser Permanente Santa Rosa*
Penny Vanderwolk - *Sutter Medical Center Santa Rosa*
Chelene Lopez - *St. Joseph Health System - Sonoma County*
Paola Diaz - *Vista Family Health Center*
Linda Garcia - *Emerita, University of CA Cooperative Extension*
Mimi Lemanski - *Community Member*
Juan Arias - *Santa Rosa Junior College Healthcare Workforce*
Elizabeth Jovel - *Community Member*
Pedro Toledo & Eliot Enriquez - *Redwood Community Health Coalition*
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2012 Education Series

California Medical Association

OCT 3

Oct. 3: Protect Your Practice From Payor Abuse
Mark Lane • 12:15 – 1:15 p.m.
CMA sponsored legislation (AB 1455 - The Health Care Provider Bill of Rights) includes many protections against unfair payment practices by health plans and insurers. Mark Lane from CMA's Center for Economic Resources will discuss important California laws that protect physicians and their practices from payor abuse.

OCT 10

Oct. 10: Impact of ICD-10
AAPC • 7:30 – 9 a.m. or 12:15 – 1:45 p.m.
ICD-10 will bring about some massive changes in healthcare. No matter what the implementation date, you need to understand how you will be impacted and what you should be doing now to prepare.

OCT 17

Oct. 17: Establishing Expectations for High Performance from Medical Staff
Debra Phairas • 12:15 – 1:15 p.m.
Superstar staff members are made, not born. Staff usually rise to the owner or manager's level of expectations. This webinar will teach physicians/managers how to set high expectations for performance, create monitoring tools to evaluate and reward staff who achieve stellar performance.

OCT 18

Oct. 18: Essentials for ICD-10-CM: Part 1
AAPC • 7:45 – 8:45 a.m. or 12:15 – 1:15 p.m.
Continued on Oct. 25 and Nov. 1
Available in either classroom or online webinar, this 3-part series gives your staff a high-level overview and fundamental knowledge of ICD-10. You'll learn documentation challenges, the differences with ICD-9, and how ICD-10 will affect each business area of your practice. Series of three.

OCT 25

Oct. 25: Essentials for ICD-10-CM: Part 2
AAPC • 7:45 – 8:45 a.m. or 12:15 – 1:15 p.m.
Continued from Oct. 18 and ends Nov. 1
Available in either classroom or online webinar, this 3-part series gives your staff a high-level overview and fundamental knowledge of ICD-10. You'll learn documentation challenges, the differences with ICD-9, and how ICD-10 will affect each business area of your practice. Series of three.

NOV 1

Nov. 1: Essentials for ICD-10-CM: Part 3
AAPC • 7:45 – 8:45 a.m. or 12:15 – 1:15 p.m.
Continued from Oct. 18 and 25
Available in either classroom or online webinar, this 3-part series gives your staff a high-level overview and fundamental knowledge of ICD-10. You'll learn documentation challenges, the differences with ICD-9, and how ICD-10 will affect each business area of your practice. Series of three.

The above webinars are being hosted by the California Medical Association. Please register at www.cmanet.org/events. Once your registration has been approved, you will be sent an email confirmation with details on how to join the webinar. Questions? Call the CMA Member Help Line at (800)786-4262.

Please note that this calendar does not include CMA's ICD-10 training courses to be offered in 2012.

Pain, Suffering and Healing at the End of Life

Andrew Wagner, MD

As a hospice and palliative medicine physician, I have had many opportunities to explore the issues and concerns of patients and their loved ones regarding alleviating pain, fear and suffering in the course of treating life-threatening illness. I have also been witness to many sacred moments of healing at the end of life.

When as physicians, we speak of "pain," we commonly limit its definition to the physical component, whether it be acute pain with a specific identifiable trigger, or chronic pain, where the inciting generator is less obvious. We have a huge arsenal of pharmacological remedies that can relieve this physical pain. There are also the modalities of physical therapy, massage and numerous other hands-on therapies, as well as integrative treatment paradigms such as acupuncture and traditional Chinese medicine, Ayurvedic and homeopathic/naturopathic medicine, chiropractic and osteopathic medicine. By using these remedies, therapies or other treatments, we often get excellent relief of physical pain.

Yet there is another side to pain, which emanates from the experience of pain as suffering. When pain is blinding, unrelenting, comes out of nowhere, just "strikes me down" . . . when a person's experience is such that "I can't take this a moment longer" . . . or "If I have to live the rest of my life like this" . . . there is suffering. There is fear . . . there is tremendous anxiety . . . there is a sense of things spinning out of control.

We must treat this dynamic of pain as well, for opioids do not address suffering. When treating suffering, we need to offer the intangible skills of empathy, of being present with our patient, of connection, of "we're in this together." If we can stay in this moment, and not get swept up in the patient's drama of the vastness of "always and forever," we can usually provide a sense of comfort that will quell this particular storm. Learning to use some deep-breathing relaxation techniques can be extremely helpful in focusing on this moment and being in the present.

In life-threatening illness, numerous fears arise, many focused around the issue of "loss." Often patients are losing physical abilities: to walk, dress, and feed themselves . . . to bathe and use the toilet. They are often losing their "role" in life. Ultimately, they will need to give up these abilities and roles, and much more. They will be giving up the people they care about and love . . . their friends, their siblings, their spouse, their children . . . and yes, even at some moment, they have to give it all up, everything . . . even their life breath, and their very own body.

Clearly this is an existential crisis. Who am I really? What is important to me? What do I value and what gives my life meaning and purpose? What is my legacy? What do I believe? What is faith? What is hope? How do I want to spend my time, and with whom? If this is my time, what do I want that to look like? Where and in what setting?

What are these conversations like? How do we address these issues? Is this medicine? Once upon a time, the "priestly" function of the physician was all that we truly had to offer. Times have changed, but this big-picture role reigns again as an integral part of palliative medicine.

The other day, I was at the home of a man on hospice, with lung cancer. He was having severe and progressive shortness of breath, and could now just barely walk across the room. His appetite was gone and nothing tasted good; he was sleeping upright in a chair because he couldn't lie flat; he was having increased pain from metastases to his spine; his legs were severely swollen from right-sided heart failure; he had the beginning of a sacral decubitus. He looked me in the eye and asked, "Doc, what can I expect?"

After clarifying his question, and knowing he wanted me to talk about dying, I shared what I have learned. That he will get weaker, and things will get harder to do; that it was time for a hospital bed (to be put in the living room, significantly changing their apartment space); that safety was important; that a fall could be devastating,

Dr. Wagner is a hospice and palliative medicine physician serving as a medical director of Memorial Hospice and offering palliative care consults at Santa Rosa Memorial Hospital.

and he needed to use a walker; that using morphine for symptom relief was appropriate; that he was vulnerable to an event, such as pneumonia, and that things could change quickly, or slowly; that we had a lot of experience in managing symptoms, and we could keep him comfortable; that his world would eventually contract, and this outer world would be less attractive and interesting . . . and he would sleep more . . . and more . . . and that he had some unknown amount of time left, to use as he wished. We talked about gratitude practices . . . and forgiveness opportunities . . . and the "Serenity Prayer" . . . and acceptance. He asked his questions, and I answered as best I could . . . and when we were done, he appeared more relaxed. The next day his nurse said to me, "Mr. X was so thankful for your time together."

Recently, I was asked to consult and meet with the family of a woman in the intensive care unit. She had critical aortic stenosis and was not a surgical candidate. She was in respiratory failure and had been on a ventilator for over a week. She had kidney failure and was being dialyzed; she was receiving total parenteral nutrition; and she was no longer alert enough to communicate. I was asked to meet with the family because, despite the futility of ongoing care and a grim prognosis, "the family just doesn't get it and they want to proceed with a tracheotomy."

I sat down with the husband and daughters and asked, "What do you know about what is going on medically with your wife?" They accurately told me all the problems, including that the doctors did not believe she would survive this illness. We talked some more about her—what she was like, what she valued, what she might want in this situation. Finally I asked, "What does it mean to you to have the tracheotomy done?" After a moment's silence, the husband, with tears in his eyes, said very softly, "I just want to kiss my wife on the lips, one last time." Too often, we simply don't know what things mean to people. We successfully extubated his wife. He had his special moment, and she died peacefully with her family surrounding her.

Often at the end of life, it is imperative to empower and inform our patients, so they have an opportunity to choose what supports their values. I once had an elderly male patient who had been in and out of the hospital over the prior six months for recurrent heart failure. I asked him what it was like to be in the hospital again, and he answered that he was tired of it all and that he hated the hospital. His wife had died a year prior. He was ready to be with her, and he wasn't afraid to die. When I asked if his adult children knew how he felt, he said no. Then I clarified that if he chose a hospice option, he would never have to come back to the hospital again. With wide eyes and a huge sense of relief, he answered "Really?" He called in his children, and I facilitated a family conference, and he went home.

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At the home of a woman with severe debilitating Parkinson's disease, I was asked to consult because she was considering "voluntary cessation of fluids and nutrition." She could barely talk, was having problems with mild dysphagia, had incontinence, was wheelchair bound, and required maximum assistance for all her activities of daily living. The only real joy she had was watching old movies and eating.

I engaged her in what was important, and it was clear she was struggling with ambivalence. Using guided imagery, I asked her to return to a time in her life when she accomplished something she wasn't sure she could do, but nonetheless had been successful. She smiled, and told me of the time she climbed Mount Hood. So we started to hike together up the trail . . . and it gets hot . . . and she's tired . . . and it's hard going . . . and she checks in with herself . . . and she accesses her "will" . . . and experiences a deep sense of "knowing" that she can do this . . . that it's important to her . . . and she does it . . . she arrives at the top. After taking some time to celebrate her success, I suggest that it is this same quality of knowing, this same wisdom and assuredness that will become apparent, if and when she is ready to stop eating and drinking. Ultimately, as she continued to access her wisdom, she never chose this option.

Another patient, a man with metastatic prostate cancer who was bedridden, did follow this path. We had spent a number of visits together, and he was sure. So we did some imagery where he experienced being in a sacred place. He took the opportunity to do a gratitude practice to his body . . . and he invited his loved ones into a circle and greeted each of them with a moment of acknowledgement . . . and when he was done, smiling and with tears streaming down his cheek, he commented how beautiful life is . . . he felt complete. He died peacefully at home eight days later with the support of his family and hospice.

My experience in being with patients and families at the end of life is that their pain, fears and suffering are intimately connected with issues of comfort, of quality of life, of "meaning," and of dignity. Also important are the concerns regarding the "pain" of loss and of abandonment. The manner in which we relate to these issues ultimately allows for healing at the end of life. This healing is a journey, a significant phase of the life cycle, and it is there for each of us.

My experiences have taught me that this healing is unique and very personal; that it occurs in the present moment; that it's not about the past (which is "gone") or the future (which we may not be a part of). It includes some measure of gratitude and forgiveness. This healing has a quality of the "sacred," and it seems to embrace "acceptance." And it includes acknowledgement and importantly, celebration. We need not be afraid. We can be present and allow this healing to unfold. ◇

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Starting Opioid Prescriptions: Pearls & Pitfalls to Preventing Misuse and Dependency

Saturday, November 10, 2012

8:30 am -1:00 pm

Vesalius Room, Sutter Medical Center, Santa Rosa

This conference features **Dr. Scott M. Fishman**, a leading researcher and national lecturer on pain medicine. Dr. Fishman is the author of "*Responsible Opioid Prescribing: A Clinician's Guide*" which translates best-practice guidelines into pragmatic steps for risk reduction and improved patient care. He is board certified in Internal Medicine, Psychiatry, Pain Medicine and Hospice & Palliative Medicine.

Learning Objectives:

On completion of this conference participants will be able to:

- Describe the epidemiology of prescription drug abuse in the U.S. and the scope of the problem in Sonoma County;
- List key steps to reduce the risk of dependency when initiating new opioid prescriptions;
- Recognize prescriber practices that contribute to misuse and abuse of opioid pain relievers;
- Identify two practices to prevent prescription drug abuse that can be implemented when treating patients with chronic, non-cancer pain.

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Program

Morning

Introduction:
Dr. Lynn Silver Chalfin, MD, MPH, FAAP
Health Officer, Sonoma County
Department of Health Services

Keynote:
Dr. Scott M. Fishman, MD
Chief, Division of Pain Medicine, UC Davis

Breakout Groups:
What do you do in your practice?
What can you do differently?

Noon

Lunch Buffet:
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Opiate Use and Misuse for Chronic Pain

Gerald Eliaser, MD

In my growing family practice at Vista Family Health Center in Santa Rosa, 17% of my panel has an assessment of "chronic pain." This percentage is consistent with published findings that chronic pain lasting more than 1–6 months has a prevalence of 2% to 40%, with a median of 15% in developed countries.[1]

A recent national survey pegged prescription drug misuse in the United States at 2.7%. For pain relievers alone, 2% of interviewees diverted them or took them "just for the feeling," or both.[2]

Given these statistics, it is convenient (if not rigorous) for me to think that for my 17 patients in 100 who complain of chronic pain, 15 will have chronic pain as the reason for seeing me, and two will have less virtuous motives. My risk of being duped is about 12%. My risk of undertreating pain resulting in pseudoaddiction is 88%. I can refine this number as soon as someone reports the actual prevalence of prescription drug addiction, separated from diversion. Until then, how can I improve my odds of meeting my obligations to both my patients and my community?

The American Society of Addiction Medicine defines addiction as "a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathology pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavior control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and dysfunctional emotional response."[3]

Dr. Eliaser is a family physician at the Vista Family Health Center in Santa Rosa.

This definition has bearing on the cases described below. The cases are fictitious, but they are based on my actual experiences. For each case, consider the following questions:

1. Was this patient an "addict?" Was he or she using medications addictively, "just for the feeling?"
2. Was he or she also taking the medication for the purpose for which it was prescribed?
3. Would you classify him or her as one of my 15% of chronic pain patients or my 2% of misusers, or both?

Case 1

AB was a 48-year-old male road worker with obesity, diabetes mellitus 2, gastroparesis, hypothyroidism, chronic phlebitis of the left lower extremity, spinal stenosis of the lumbar region with sciatica on the right, alcoholism in remission with bad consequences for his past family life, and denial of use of illicit drugs in the past year. His medications included methadone three times a day, oxycodone as needed, gabapentin three times a day, naproxen twice a day, cyclobenzaprine at bedtime, and zolpidem at bedtime.

One day while working at a road site, AB grabbed his chest and collapsed. Paramedics were called and resuscitation performed. Upon arriving at the hospital, his rhythm was chaotic, and he ultimately died. When informed that his father had died quickly, AB's son expressed regret that AB hadn't suffered more so that AB could feel what it was like for his son to suffer as a child during the height of AB's alcoholism.

Case 2

CD is a 29-year-old male presenting with interscapular pain whenever he carries anything. He attributes this to a head-on motor vehicle accident over a year ago. He is asking for disability and pain medications. He admits to taking Norco, Soma and ibuprofen from a friend. His urine drug screen shows methadone, benzodiazepines, opiates and oxycodone. His examination has inconsistency in findings. He is not in withdrawal.

Case 3

EF is a 34-year-old female with metabolic syndrome, schizophrenia, and low back pain attributed to her weight. She has a past history of alcohol abuse but has been sober for several years. She was stable on haloperidol, benztropine, lorazepam and Norco four times a day

and was beginning to get into the community and participate in life. Then her weight and back pain started increasing. Her labia became red and edematous, and the pain was such that she would or could not avoid overusing Norco. Her anxiety also increased, and she was switched from lorazepam to chlordiazepoxide to smooth out her levels.

To prevent an acetaminophen overdose, I told her to stop the Norco and replaced it with oxycodone. Her weight started to decrease, but then she fell and twisted her ankle, leading to more pain and overuse. She became lethargic and was brought to the emergency department. X-rays were negative, but the ED physician noted the patient taking her own lorazepam and oxycodone. The staff took these away. In the following week, even while her edema was decreasing, her opiate use became unmanageable, and prescriptions had to be filled daily to prevent overuse.

Packer and Addison list four approaches to evaluating an interpretive account: coherence, external evidence, participants' interpretation, and consensus.[4]

In Case 1, the history and exam hold together. My prescriptions and the patient's goal-congruent behavior also seem to hold together, although he could have sold some or all of the medications that I prescribed. Even his history of the sad consequences of his alcoholism on his family held together with his son's post mortem statement.

What about external evidence? The girth of his left leg was 2 cm greater than that of his right. His Patient Activity Report from the Department of Justice showed he was filling prescriptions only from me. The participants' interpretations (patient, son, staff, physician) were all consistent with a person challenged in his relationships. This still does not answer the question of diversion of some or all medications. Finally, is there a consensus on the appropriateness of care? Who needs to be included in the consensus?

To answer the questions above: 1) AB was an addict, but not to prescription opiates. 2) He was taking the medication for the purpose prescribed. 3) As defined by SAMHSA, he was not in the 2% of my misusers, but the definition does not refer to him diverting his prescription for someone else's misuse.

In Case 2, the history and exam do not hold together. Neither does the urine drug screen and CD's report of what he has taken. Misuse, including addiction, is a likely interpretation in this case. The answers are thus: 1) CD is likely an addict to prescription medications. 2) I am unsure if he was taking the medication for the purpose provided. Conceivably he could come back without opiates on board and have a consistent exam. 3) He is among my 2% of misusers, given the content of his urine.

In Case 3, EF's story is consistent with having chronic pain related to her back and acute pain to her ankle. She also has a story consistent with addiction to at least pain relievers and perhaps also sedatives. There is external evidence from her, her family, and her providers that she fits the ASAM description of addiction to prescribed medications.

For EF, the answers are: 1) She is addicted to prescription medications. 2) She was also taking the medications for pain relief. 3) She is in my 15% chronic pain group and in my 2% of misusers as an addict.

Could some other medications have been used that would have avoided the risks inherent in the cases described above? The ASAM definition of addiction involves "brain reward, motivation, memory and related circuitry." There are medications that can dampen that mechanism and flatten affect. But then there would be less joy and motivation in living. Maybe the researchers studying these circuits can find a way to make "the right adjustments" and keep the joy. This is Brave New World stuff, and I am not sure if it is preferable to what we have. At least now there is a way relationships can deepen from the experience.

Using only medications implies that the problem requires medications to be solved. We have other arts that can deal with pain, such as relaxation, biofeedback, acupuncture, osteopathic manipulative treatment, body work or chiropractic. Each implies a relationship between the practitioner and patient. At bottom, I wonder if the specific art is as necessary as the relationship. ◇

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Substance Abuse During Pregnancy

Erin Lunde, MD, MPH

Use of legal and illegal substances among reproductive-aged women in the United States is extremely common. A recent national survey found that more than 50% of these women drank alcohol in the past month, and 25% reported binge drinking, as defined as more than three drinks per occasion.[1] About 30% of them smoked tobacco, and another 10% used illicit substances in the past month. Another relevant statistic is that more than half the pregnancies in the United States are unexpected. For these women, pregnancy is often an unwelcome surprise.

Given these statistics, it's not surprising that a large number of women, particularly those with unexpected pregnancies, abuse substances during pregnancy. As physicians, we need to understand the factors that lead to substance abuse among women and how best to identify and support women who are unable to quit on their own once they become pregnant.

Pregnancy represents a unique opportunity to successfully introduce treatment for substance abuse disorders. No woman intends to hurt her baby with ongoing substance abuse, and many are able to stop using once they learn of the pregnancy. Rates of use for alcohol, illicit substances and to a lesser extent tobacco typically decrease from the first through third trimesters of pregnancy. Women who pre-pregnancy may not have been ready to stop using substances often come to acknowledge the severity of their addiction when they are unable to stop using in pregnancy, and they become motivated to seek treatment.

Addiction is a chronic medical disorder that has traditionally been treated as a moral problem rather than a medical condition. Our approach has historically been on an individual level, treating substance abusers as merely lacking the willpower to stop using. More recent research has begun to identify many of the root causes that lead individuals to use substances in the first place. Addressing these underlying problems is critical for resolving addiction.

Research has also found that women and men differ in their reasons for substance abuse and thus need different approaches to treatment. Women more frequently initiate substance use as a result of traumatic life events, such as physical or sexual violence or other disruption in family life.[2] Also, women are often drawn into substance use by their partners or were raised in families with heavy alcohol or drug use. Women are more likely to have poor self-concepts and high rates of mental health problems, specifically depression, anxiety, bipolar disorder, suicidal thoughts, eating disorders and posttraumatic stress disorder. Finally, social stigma, labeling and guilt tend to be much greater for women than men and are major barriers to women receiving treatment. To help women suffering from addiction disorders in pregnancy, we must address all their social and emotional needs so they can work on recovering from addiction and prepare themselves for the demands of motherhood.

While use of illicit substances during pregnancy receives much attention from the media, the actual effects on the fetus from most illicit drugs are poorly elucidated and likely much less than we think. In contrast, alcohol use in pregnancy receives much less media attention, despite alcohol's clear role as a teratogen and its higher rates of use. Sonoma County actually has the highest rate of alcohol use in pregnancy in the state of California, and almost twice the national average. In a recent survey, 18% of the pregnant women in Sonoma County reported using alcohol during the first or third trimesters, and 6% reporting binge drinking during pregnancy.[3] By comparison, the county's smoking rates are lower than average, with just under 9% of pregnant women reporting any smoking during the first or third trimester, compared to nearly 18% nationally. Precise local data on rates of illicit substance use in pregnancy are lacking, but the national average is approximately 4% of pregnant women.

Fetal alcohol syndrome most likely

Dr. Lunde is a family physician at Vista Family Health Center in Santa Rosa.

results from heavy alcohol use throughout the first trimester, although a wide variety of alcohol-induced effects classified as fetal alcohol spectrum disorders result from varying amounts of alcohol ingestion during all three trimesters of pregnancy. Approximately 1% of children born in the United States are affected by one of these disorders.[4] There is still no known safe amount of alcohol use in pregnancy, although women with heavy use or binge drinking have a much higher risk of having children with an alcohol-related disorder.

Contrary to stereotypes, women who are older, wealthier, better educated and Caucasian actually have the highest rate of alcohol use during pregnancy. Yet these women are less likely to be asked about alcohol or drug use than poor or minority women. Punitive efforts directed at pregnant women who use substances have disproportionately singled out poor and minority women who use illicit substances and ignored women who drink or smoke. If we truly want to improve obstetric and fetal outcomes, we should target our interventions toward reducing alcohol and tobacco-exposed pregnancies. These exposures have much more clearly defined risks and affect a greater number of pregnancies than illicit drugs.

Although alcohol and tobacco continue to be the main problem, the use of opiates during pregnancy has increased dramatically over the past decade, resulting in higher rates of neonatal abstinence syndrome.[5] This withdrawal syndrome, the most clinically significant harmful effect of opiate use during pregnancy, occurs at similar rates for both medically prescribed opiates and their illicit cousins. Nonetheless, prescription methadone or buprenorphine are preferable to illicit opiates in opiate-dependent women and result in improved obstetric outcomes. There is insufficient data comparing short-acting prescribed opiates such as Vicodin, Norco or Percocet to longer-acting opiates in pregnancy. Both methadone and buprenorphine can lead to neonatal abstinence syndrome, but rates of poor fetal growth and preterm labor are reduced. In addition, mothers taking these medications are more likely to obtain regular prenatal care and be in a position to successfully raise their babies than women continuing to use illicit opiates.

In many states, use of illicit substances during pregnancy is a major reason for Child Protective Services involvement at the time of birth, and many women have had their parental rights removed as a result. Though some women who continue to use substances during pregnancy are truly not in a position to change their behavior and provide a healthy environment in which to raise a child, many are able to become good mothers if we provide them with resources and support.

The United States still takes a punitive approach to illicit substance use, and many women are incarcerated each year for use of drugs during or after pregnancy. Despite the prevalence of this approach, there is strong evidence to show that incarceration is a poor form of substance abuse treatment.[6] Prison is not a healthy environment for women who are pregnant. Compared to high quality residential treatment programs, incarceration costs 4–5 times as much per woman, with much higher rates of relapse after release. Women who are using drugs in pregnancy need treatment and support, recognizing the complex reasons for their use and addressing the social and emotional factors that contribute to their addiction. In my view, this public-health approach to substance use in pregnancy will ultimately lead to better outcomes for mothers, children and communities while costing less than punitive approaches.

My own approach to substance abuse in pregnancy is to screen all women during the first prenatal visit by asking in an open, nonjudgmental way about past and current use of tobacco, alcohol or drugs. If the patient has had any use since becoming pregnant, I try to elucidate timing and quantity of use. For any patient with ongoing use, I advise her to quit during pregnancy, citing the known risks to her health and pregnancy. Then I assess how likely the patient thinks she will be able to quit, and we identify barriers to quitting. Finally, I offer resources to help her reduce use or quit completely.

The most important part of this initial visit is to refer any patient who seems to be having difficulties quitting and to follow up at subsequent visits. Often the stresses of pregnancy will cause patients to relapse. We should expect relapse to be the norm and should continue to ask about use and to assess their need for support.

Many physicians seem to think that random urine tests are a sufficient way to screen for substance abuse in pregnancy. My concern is that this random screening sets up a dynamic with our patients where we appear to be trying to "catch them" rather than having an honest and nonjudgmental dialog with them about what's important for a healthy pregnancy. A woman's fear

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of being "caught" may lead her to miss prenatal appointments and erodes the patient-physician relationship.

Just like any medical test, urine or serum drug tests should only be performed with the patient's informed consent, particularly because the results of such a test may have negative consequences down the road. A single urine sample does not truly illustrate a woman's ability to be a successful mother, nor does it tell us what type of support she may need. I only send drug screens with a woman's express consent, or on a baby after it is born, if I am concerned about substance exposure or signs of withdrawal.

For women needing referral to substance abuse treatment in pregnancy, there are several excellent gender-specific options in Sonoma County, both residential and outpatient. Some of these include the Drug Abuse Alternatives Center Perinatal Day Treatment Program, and both the Casa Teresa and Women's Recovery Services residential treatment facilities. As true gender-specific programs, these treatment centers allow women to bring their dependent children with them. They also provide transportation, case management, and mental health assessments and treatment.

Additional resources are available through the Drug Free Babies and Smoke Free Babies programs. Sharon Youney, the perinatal services coordinator at Drug Free Babies (707-236-2362), can help pregnant or recently postpartum women access residential or outpatient substance abuse treatment. Michelle McGarry (707-575-6043, Ext. 19, or mmcgarry@nccwb.org) can provide information about the Smoke Free Babies program, which helps women reduce or eliminate tobacco use in pregnancy through individual and group counseling. The various Public Health nursing programs are also invaluable resources for pregnant women who need additional education and support to prepare for the difficult tasks of childbirth and parenting. ◇

Email: erinl@srhealthcenters.org

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Reducing Opioid Use in Women of Reproductive Age

Rebecca Munger, CNM, PHN

While alcohol and illicit drug use in pregnancy are of serious concern, there is growing awareness that misuse and abuse is not limited to illicit drugs. According to the CDC, 12 million Americans reported nonmedical use of prescription painkillers in 2009. This misuse can be attributed in part to the increased availability of prescription painkillers: between 1999 and 2010, the quantity of these medications sold in the United States rose by 400%. During approximately the same period, the number of unintentional lethal overdoses involving prescription opioids increased by more than 350%.

Misuse of prescription drugs is an important local issue. According to data released by the Substance Abuse and Mental Health Services Administration in 2010, Sonoma County ranked second in the state for prevalence of nonmedical use of pain relievers among people older than 12. Research conducted by SAMSHA also shows that women are significantly more likely than men to use and abuse prescription medications. It is therefore not surprising that local hospitals are encountering new mothers who have been on large doses of opiates and other controlled substances.

Over the past few years, labor and delivery units throughout Sonoma County have reported a rise in the number of newborns withdrawing from legal drugs. Their experience is supported by data showing that the rate of newborns discharged from local hospitals with a diagnosis of neonatal abstinence syndrome (NAS) increased from 1.6 per thousand newborns in 2004–06 to 3.0 per thousand in 2008–10. This increase closely mirrors a national trend.[1]

The average length of stay for infants diagnosed with NAS is 16 days. When these numbers are applied to Sonoma County's 5,000 annual births, the cost of hospital care for the group of 15 babies with NAS is over $600,000 a year. This figure represents just the initial investment in caring for babies with NAS—not the developmental and medical needs after discharge, which can be considerable.

In addition to the economic impact, NAS takes a personal toll on families. Women who are taking opioid medications at the direction of their physician to treat pain have expressed surprise and felt betrayed that they were not protected from putting their unborn child at risk. Use of prescription medications is a problem that needs to be addressed before labor and delivery.

Last year the Sonoma County Department of Health Services (DHS) got a chance to move upstream and address alcohol and drug use before pregnancy. The CDC's National Center on Birth Defects and Developmental Disabilities provided funding to create a national practice collaborative focused on reducing the number of pregnancies exposed to alcohol and other substances. Sonoma County was selected for the collaborative along with five other communities across the country: Baltimore, Dayton, Tampa, Denver and Sonoma County DHS has enlisted sev-

City MatCH Partners

Local partners for the City MatCH Initiative include the Santa Rosa Family Medicine Residency, Santa Rosa Community Health Centers, Petaluma Health Center, Partnership Healthplan of California, Santa Rosa Kaiser Permanente, Drug Abuse Alternatives Center, Women's Recovery Services, The Living Room, and Planned Parenthood. Our team is also joined by a prevention specialist from the Santa Rosa-based Center for Applied Research Solutions and a pediatrician with the California Department of Public Health.

Ms. Munger, a certified nurse midwife and public health nurse, coordinates Sonoma County's Maternal, Child and Adolescent Health program.

eral local partners to help implement the CityMatCH initiative (see box on previous page). Our overall goal is to reduce risky use of alcohol and drugs among women of reproductive age before pregnancy, and we have selected three strategies:

- Institute screening and brief intervention for alcohol and drug use as a routine part of well woman care at three primary care sites.
- Promote use of long-acting Tier 1 contraceptive methods, like IUDs and implants, among women who continue to engage in risky behaviors.
- Increase awareness among physicians and community members about misuse and abuse of opioid prescription drugs.

The remainder of this article discusses the third strategy. While the CityMatCH initiative focuses on women of reproductive age, we believe these principles apply to the community as a whole. Our initial focus is on primary care settings, but emergency departments and dental offices are also important sources of controlled substances.

Responsible Opioid Prescribing

Adopting strategies that reduce the potential for abuse of prescription pain relievers will require practice changes for physicians. Many clinicians lack experience managing pain without opioid pain relievers, and they need guidance on how to avoid common pitfalls when they do give opioid prescriptions.

CityMatCH has been researching what clinicians can do to appropriately treat pain without leading patients on a path to dependency. Starting opioid prescriptions requires both clinician and patient alike to be aware of the risks of long-term use and consider safer alternative modalities to treat their pain (see sidebar).

To help clinicians understand these issues, we will be holding a half-day CME conference on Saturday, Nov. 10, titled "Starting Opioid Prescriptions: Pearls & Pitfalls to Preventing Misuse and Dependency." The keynote speaker is Dr. Scott Fishman, chief of the UC Davis Division of Pain Medicine. He is a nationally recognized leader in pain management and the author of "Responsible Opioid Prescribing: A Clinician's Guide." (See the course announcement on page 20 for registration information.)

Educating Our Patients

Patients need to be educated about securing and disposing of controlled substances to prevent diversion and accidental poisoning. Experts recommend that home lock boxes be used to keep medications out of reach of young children and teenagers. According to the National Poison Data System, calls to poison centers for pediatric pharmaceutical exposures have increased dramatically since 2001. Visits to the emergency department by young children for medical poisoning now exceed motor vehicle occupant injuries.[2] Opioids, sedative-hypnotics and cardiovascular medications are the drugs most often involved in these poisonings.

Teenagers need additional protection. According to a recent national survey, more than half the teens surveyed think that prescription drugs are safer than illicit drugs and find them easy to get from family and friends.[3] A California survey found that 50% of 11th graders reported using either an illegal drug or a diverted prescription drug to get high or stoned at least once.[4]

Our group is partnering with Safe Kids Sonoma County, and we just received a Healthy Living Grant from the American Medical Association Foundation to educate parents on how to protect their young children from accidental poisoning and reduce the risk of diversion by teenagers. In addition the grant will support youth education about prescription drugs in middle and high school classrooms.

Policy Changes

Policy changes on both the state and federal level need to be part of the solution. Consumers and physicians, for example, could help advocate for a policy change that would make disposing of unused opioid prescriptions easier. Most prescription take-back programs specifically exclude controlled substances because of DEA regulations.

Policy changes are also needed for prescription monitoring programs,

Initiating Opioid Prescriptions

The following opioid prescription basics are adapted from Physicians for Responsible Opioid Prescribing (www.responsibleopioidprescribing.org) and California CURES (www.oag.ca.gov/cures-pdmp).

Explain to patients that opioids are for time-limited use. Set expectations that they should be discontinued when the pain problem is no longer acute.

Limit all initial and refill prescriptions for acute pain to the actual number of pills you expect will be needed. A 30-day supply is often excessive—many patients only take a pill or two then leave the rest unused in their medicine cabinet.

Extended-release opioids are not appropriate for managing acute pain. These should never be prescribed to an opioid-naive patient.

Avoid routine authorization of opioid refills for acute problems.

Before initiating chronic opioid therapy, other safer alternatives should be considered, including primary disease management, cognitive-behavioral therapy, physical therapy, non-opiate analgesics, and exercise.

Long-term opioid prescribing should only occur after careful patient evaluation, discussion of risks and realistic expectations of benefits, and clear explanation of prescribing ground rules for safe use.

Use California's prescription monitoring program CURES to identify patients who might be misusing or diverting opioids and other controlled substances. To register, visit www.oag.ca.gov/cures-pdmp. (CURES stands for Controlled Substance Utilization Review and Evaluation System.)

which have proven effective in preventing diversion. Local prescribers are encouraged to use California's Controlled Substance Utilization Review and Evaluation System (CURES). Unfortunately, CURES is constrained by financial cuts due to the state budget crisis. CURES is a valuable resource for physicians and pharmacies that should be maintained and expanded to operate in real time, like similar programs in other states.

Prescription drug abuse is a growing problem nationally and here in Sonoma County. Every clinician needs to take responsibility for preventing opioid misuse and abuse. It is time to rethink the practice of sending a patient out of the office with a 30-day supply and refills of an opioid to treat acute back pain. As stated in a recent editorial in Annals of Family Medicine, "Entering into chronic opioid therapy requires a long-term commitment by clinician and patient alike to use this powerful, precious, and dangerous medication with care and diligence." [5]

Along with community partners, Sonoma County DHS is working to increase awareness of the problem and encourage responsible prescribing, as well as safe medication storage and disposal. Without cautious and selective prescribing, treatment of acute pain has the potential to lead to chronic opioid dependence, as well as diversion of medications to unintended users. ◇

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I would like to acknowledge the contributions of Dr. Marshall Kubota, Dr. Mark Netherda, Lynn Scuri, Dr. Lynn Silver-Chalfin and Terese Voge in writing this article.

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Heart & Brain Symposium in Santa Rosa on Oct. 13

Physicians throughout Sonoma County are invited to attend a free half-day symposium, "Regional Care Coordination: Treating the Heart & Brain," on Saturday, Oct. 13, at the Vintners Inn in Santa Rosa. The keynote presenter is Dr. David Bonovich, who will discuss multi-disciplinary regional coordination of neurocritical care. Other presenters include Drs. John Reed, Thomas Dunlap, Tucker Bierbaum, Patrick Coleman, Emily Conway, Peter Chang-Sing, Ramzi Deeik, and Jay Hunter, as well as Christo Brockway, RN.

The symposium, which is sponsored by St. Joseph Health, begins with breakfast at 8 a.m., followed by speakers until 12:15 p.m., and then lunch. To RSVP, contact Janette Lablue at Janette.Lablue@stjoe.org or 707-525-5300, ext. 3389.

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Public Health Officer Lynn Silver-Chalfin, MD, MPH

Steve Osborn

Sonoma County's new public health officer, Dr. Lynn Silver-Chalfin, was born and raised in New York City. She received a BA in biological sciences from UC Santa Barbara in 1977 and a combined MD/MPH from Johns Hopkins in 1983. In 1989, after completing a residency in pediatrics and a fellowship in international health, she moved to Brazil, where she spent the next 14 years working as a professor of public health, a researcher, and an administrator. She left Brazil in 2002 to become a visiting scholar at the Karolinska Institute in Sweden, and then became assistant commissioner of public health for New York City in 2004. While there, she led several high-profile initiatives, including a trans fat ban, a calorie labeling law for restaurants, and a salt reduction initiative.

Dr. Silver-Chalfin was appointed public health officer for Sonoma County earlier this year, and she began working full-time in August. The following interview was conducted in her office at the Department of Health Services on Aug. 24.

Mr. Osborn edits Sonoma Medicine.

You became assistant commissioner of public health for New York City in 2004. What did that job involve?
They recruited me to work coordinating their chronic disease prevention and control. It was, to some extent, what they call a "blue sky" task, where you really have to think through a field and try to understand how you can achieve significant change. The doors were open to thinking about new strategies.

For many years, the strategies in chronic disease had been to deliver messages to individuals to change their behavior—but that hadn't been terribly effective. We saw a continuing obesity epidemic. People's diets had not changed; physical activity levels continued to be low; we had a huge and burgeoning epidemic of diabetes and obesity; and tobacco continued to be the leading cause of preventable death. So when I was looking at the situation, I was really trying to identify what could be effective approaches to reducing risks of chronic disease in a large population.

And what did you discover?
My conclusion was that, in addition to improving health care and preventive services, we really had to look at the environmental determinants of chronic disease. Like many other researchers, I concluded that the obesity epidemic did not occur strictly as a result of individual behavior; it was occurring largely as a result of changes in the organization of our food supply, the way food is supplied and marketed to the American people, and changes in our physical environment. And so our department tried to look at how we could make changes in these environmental determinants of chronic disease. We asked how we could make sure our citizens had access to a healthier food supply and how physical activity could be built back into daily life.

For the most part, these weren't choices that people had made. Trans fat, for example, was an artificial fat that had been added to the food supply 100 years ago because it was more stable and had real industrial advantages. It was something that came into the food supply without really being assessed in regard to safety. And then research showed that trans fat was actually a significant contributor to heart disease. So we asked, "Why are we still using this in our food supply in New York, where we traditionally regulated restaurants?"

We initially asked restaurants to voluntarily remove the substance from food preparation. We were not successful with the voluntary campaign, so we moved to regulate trans fat and remove it from food preparation in restaurants. That measure changed the default for cardiovascular disease in a very effective way. It's a good example of the environmental-change approach to reducing cardiovascular disease. Everybody's favorite foods are still for sale.

Another measure you implemented was the calorie labeling law, which required restaurants to list the amount of calories for each item on the menu. How effective has that been?
It has been very effective in terms of reaching people. The polls in the city show that 84 percent of New Yorkers like it and find it useful. Not everybody uses it, however. In only about 15 percent of a given group of visits do people use it to decide on their purchase, and then people purchase about 100 calories fewer. We did fairly extensive evaluations. The law did not reduce calories for everyone, but it did lead many businesses to reformulate some of their products, and that may be the largest long-term effect.

What is the current status of the law?
The calorie labeling law spread to a significant number of jurisdictions across the country and was then included in health care reform, so it is now a national requirement. The FDA has not yet completed the regulation, but I expect that it will be in effect nationally for chain restaurants in 2013.

You also had a salt reduction program. How did that work?
That was a national voluntary program modeled on a successful program in the United Kingdom looking at working with the food industry to voluntarily reduce the levels of salt in processed food. The recommendations for daily salt intake are no more than 2,300 milligrams per day for most adults and 1,500 milligrams for certain groups. On average, Americans eat about 3,400 milligrams of salt a day.

The salt reduction program was a national effort that was launched by New York City, but we brought in more than 70 organizations from across the country, and we held over 100 meetings with different industry groups producing different types of food. We set voluntary targets for reduction for 2013 and 2015, and their implementation is being monitored.

So you came to an agreement with the manufacturers?
We had a discussion with them. We set targets, and we asked manufacturers to commit to those targets. The last I looked, 28 manufacturers had made commitments. So some manufacturers committed publicly to meeting targets. Others launched their own internal salt reduction policies but did not necessarily commit publicly, and some did nothing.

Are you optimistic that the government can do similar things with other additives, such as high fructose corn syrup?
If you look at elements in the diet that are associated with the obesity and diabetes epidemics, high consumption of added sugars is a huge problem. High fructose corn syrup is one of the forms in which that sugar is delivered cheaply. I tend to think that the bigger problem is the total amount of sugar, whether in the form of high fructose corn syrup or others. A 20-ounce bottle of soda has 16 teaspoons of sugar in it. I mean, how much sugar do you add to your coffee?

I add none.
And if you did add sugar, how much would you add?

One or two teaspoons at the most.
You wouldn't add 16, right? Taking 16 down to something reasonable and having people shift to drinking beverages that have less added sugar or drinking smaller amounts of the ones that have added sugar is a huge challenge. I think similar approaches, whether voluntary or regulatory, are needed because our very elevated sugar level is a very important contributor to obesity and diabetes.

What do you think the role of the government should be in regulating the American diet?
I think the first thing that people should be aware of is that their diet is already being regulated by the food industry. The diet is being manipulated by the food industry in ways that are extremely bad for people's health. The soda companies have a target of increasing the amount of ounces that the American public consumes every day. That is one of their indicators of success: How many ounces of our products do people consume? And the high-sugar versions of those products have been very clearly associated with disease.

People have been calling upon the industry to change its practices, and we are seeing a little more diversification of offerings. But there are still huge marketing pushes to get people to consume large quantities of sugary drinks that are clearly leading down the road to diabetes and other chronic illnesses.

So what is the role of government? It is the role of government to regulate the safety of the food supply. People have accepted for many years that government acts to keep you from getting infectious diseases from food. But people didn't always accept that. It took Upton Sinclair writing *The Jungle* and national protests and scandals and people dying

from infectious disease for the Food, Drug, and Cosmetics Act to pass and for it to be conceived as a role of government to regulate the safety of the food supply.

Today, the biggest problem in food is chronic disease. Diabetes and heart disease are related to food. So one has to ask: Is it the role of government today to try and help address those risks? I don't think government is going to take away your choice of foods. Government is not going to ban desserts. People want and should have variety and choice in their food supply, but they should also not have a food supply that routinely causes severe illness. So finding the sweet spot—the appropriate balance between having a joyous, delicious and varied food supply, and not having unhealthy foods that are causing a large number of deaths aggressively marketed to the population—is a challenge for public health.

You were involved with the proposal to limit the size of sodas sold in New York City. Is that an example of government stepping in and saying, "Here's how we're going to try to change your behavior"?
I would say that soda size is an example of McDonald's and Burger King and major beverage companies stepping in and saying how they are going to change your behavior. In the 1950s, McDonald's only sold a seven-ounce soda for adults. That was their drink. And over the past 50 years that seven ounces grew logarithmically, so now that size is smaller than the children's soda. Meanwhile, the regular soda bottle went from being six ounces to being 10 ounces to being 16 ounces, to the current one, which is 20 ounces—and supersized ones go up to 60 ounces. So really, who is regulating soda intake has not been government. It has been the food and beverage industry, and it has pushed soda consumption to a point where it is a major contributor to the fastest growing cause of illness in the United States, obesity and diabetes. At some point, it has to stop.

What about putting warning labels on soda like the ones on cigarette packs? Is that another possible solution?
That would be an alternative. I think the issue there is that the problem really is sugar. And sugar is not a sin in reasonable quantities. People eat desserts, people put a couple of teaspoons of sugar in their cup of coffee or make some lemonade once in a while. It is really a matter of the quantity. It is a matter of having 16 teaspoons several times a day instead of 2 or 3. A warning label is an approach that could be used, but you don't want to put a warning label on all sugar. Sugar in reasonable amounts is fine.

Some of the other New York initiatives involved changing the so-called "built environment" to promote physical activity, such as making staircases more prominent in buildings. How successful were those initiatives?
The obesity epidemic is a balance between not enough physical activity and too many calories. Irrespective of your weight, the more exercise you get, the more you reduce cardiovascular risk. A number of architects and other people have noted that our society has progressively "designed out" physical activity in our environment. So we use cars, we take elevators and escalators instead of going up the stairs, we don't bicycle, we don't walk, we use electric toothbrushes. And instead of dancing, we watch TV.

In many realms—whether it's work or transportation or entertainment—we have designed out physical activity. And the challenge is: How do you design that back in a way that continues to be pleasing and aesthetic but lets people use their bodies for their intended uses? And so we began a collaboration in 2005 with the American Institute of Architects to examine ways to have the city environment promote physical activity. Out of that grew a collaboration with the many city agencies involved in design and construction to create something called the Active Design Guidelines.

Those guidelines included things like having stairwells being more prominent in buildings, having parking for bicycles, encouraging bicycle paths and walking paths in the design of buildings, encouraging physical activity spaces in residential buildings and work buildings. The city actually issued those as an official set of city guidelines for construction. And in the year or two prior to my leaving New York, they began to incorporate them into bids for construction proposals.

Do these guidelines only apply to new construction?
Some of it is for new, and some of it for old. We began to work with buildings to open up their stairs and put up signs encouraging people to use their existing stairs. We distributed thousands of those prompts, and hundreds of buildings bought into it and began to do that. Many hospitals around the city now have open stairwells and stairwell signs, and people know where the stairs are, and they use them more. Promoting stairs was a very simple, low-cost approach to getting people to build physical activity into the things they do in everyday life, like going up to the office or going down for lunch.

If your office is on the 35th floor of a skyscraper, are people actually climbing all 35 floors to their office?
I was on the 20th floor, and I did have a couple of really gung-ho staffers who would go up 20 floors. But most of us wouldn't.

But if you're going between floors, you might use the stairs?
Yes. We went from the 17th floor to the 22nd floor, and we opened up our stairs and put up the signs, and people would go back and forth between those floors fairly routinely.

Of all the initiatives that you worked on in New York, which ones do you think need to be implemented in Sonoma County?
Some of them you already have. For example, California has implemented trans fat restrictions in restaurants. The

work we did on publicly financed food is also being done all across California and here in Sonoma County, making sure that food that is delivered through public services is healthy. Not only that it tastes good, but that it is healthy food. We are working on that.

Sonoma County may be a smaller and easier place to engage in voluntary initiatives. I think it is on a scale where people know each other in communities, and it may be easier to work together voluntarily. People from across different sectors are working on health issues through partnerships like Health Action. I am optimistic that we can work with people active in these different areas to achieve some of these goals.

One of the big challenges in Sonoma County is the built environment. Santa Rosa is a classic example of suburban sprawl. You basically can't get around unless you have a car. How would you encourage physical activity given that situation?

Addressing sprawl is a growing challenge, and groups of architects and planners within the state have been very active in trying to create new models for communities, including public transportation hubs, the ability to walk to commerce, and so forth. It is a discussion that I think needs to take place as we have new development in the community. How we can design our communities to be less car-centric or car-dependent? Encouraging active transportation—whether it is walking, bicycling or just using public transportation—is an important goal. There is a whole movement across the state for what is called "health in all policies"—trying to think through how policies in a variety of areas like transportation and others affect health.

As a public health physician, you are proactive on disease prevention, and you take a population view of how to do that. But what about physicians in clinical practice? They are the ones who have to care for patients with diabetes and obesity and all the other conditions related to public health.

The role of physicians is critical in prevention. What a physician says to their patient matters. Hearing it from your doctor is important, probably more important than hearing it from your health department. What physicians say in their communities also matters.

Tobacco and dietary issues like sugary drink consumption are very important, and doctors need to address those issues with their patients. Doctors have a lot of things on their plates and are stressed for time, but these are very important issues that end up being major determinants that kill our citizens. Tobacco and obesity are the two leading causes of preventable death.

Physicians can also be advocates in their communities as we try to have a healthier food supply, to have restaurants serve reasonable portions, to have supermarkets and corner stores sell fruits and vegetables that are delicious. Physicians can play this critical role of being both advocates in their communities and the most important advocates with their patients.

How do you think the medical association should be involved in public health? Did you work with the medical association in New York?

Yes we did. We worked with the national associations and the local associations. We had a program that went out in the community called "public health detailing." We visited thousands of physicians regularly with messages and information and tools on key public health issues. We did trainings on addressing pediatric obesity in your practice, addressing adult obesity, detecting depression, treatment of hypertension, and smoking cessation, for example, and we provided tools and other clinical supports to help clinicians implement prevention in their practices. That was a very positive collaboration. It was actually modeled on drug detailing, which sadly is an effective model for reaching physicians, only our purpose was quite different.

What are the big challenges here in Sonoma County? You have only been here a short while, but what kind of fiscal and political challenges are you facing?

Well first thing, the strengths. I think we have a county that is very interested in health and in creating a healthy environment. We have organizations like Health Action, which have brought together people from across different walks of life to look at different health issues and to take action. We have a great team at the Department of Health Services, and we have county supervisors who are committed to health as an issue. So, those are very positive aspects.

Like the rest of the nation and California, we are suffering from the effects of the recession. Staff complements have been reduced, numbers of people that we have available to work in different areas are scarcer than they have been in the past. So we have to really think about how to use resources effectively and efficiently to help create health. That is a challenge, I think, for all of the agencies—for schools and fire departments, and everybody.

Some of the problems here are the same as in New York. Tobacco and obesity are also epidemics here, and we need to address them. We have significant health disparities and communities within the county that suffer from both poverty and higher disease rates. We need to reduce those disparities.

Are you optimistic that the public health department is moving in the right direction?

This is going to be a great place to work. I think we are going to make real progress. From what I have seen of the medical community, I think this is a medical community that cares about the people in the county and has been engaged in many initiatives over past years to improve public health. I am confident that they will be tremendous partners to improve public health in the county over the coming years. ◇

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Wood Smoke Pollution

Ina Gotlieb, MA

Wood smoke vs. other pollutants

Pollutant	Diesel Emissions	Tobacco Smoke	Wood Smoke
Benzene	X	X	X
Carbon dioxide	X	X	X
Carbon monoxide	X	X	X
Dioxin	X	X	X
Formaldehyde	X	X	X
Lead	X	X	X
Methane	X		X
Nitrogen oxides	X	X	X
Particulate matter	X	X	X
Polycyclic aromatic hydrocarbons	X	X	X

While most Americans are aware of the risks posed by secondhand tobacco smoke, we rarely think of our fireplaces, woodstoves, and outdoor fire pits and chimneys as hazards to our health. People who would never dream of smoking a cigarette think nothing of burning wood because it seems so "natural." Yet wood smoke contains many of the same toxic and carcinogenic substances as cigarette smoke and has many of the same health impacts. Enacting laws to reduce public exposure to secondhand tobacco smoke took more than 30 years—but it is not necessary to wait for new laws and regulations to reduce wood smoke pollution and its effects on our health.

California has categorized secondhand tobacco smoke and diesel exhaust as Toxic Air Contaminants, and both are now regulated by the state to reduce public exposure. Like wood smoke, both cigarette smoke and diesel exhaust produce complex mixtures of substances that are proven hazards to human health. The table above illustrates the similarities between these three sources.

Ms. Gotlieb is the program director of Families for Clean Air, a Bay Area nonprofit organization.

The process of wood burning creates dioxin—one of the most toxic and persistent substances on earth.[1] According to the Bay Area Air Quality Management District, one-third of the total amount of dioxin in the Bay Area comes from wood burning.[2] Wood smoke also contains other toxic and carcinogenic substances, including dibenzocarbazoles and mercury.

Diesel exhaust, cigarette smoke and wood smoke contain high concentrations of particulate matter, which epidemiological studies have linked to morbidity and mortality. Wood smoke produces far more particulate pollution than cigarette smoke. EPA researchers estimate the lifetime cancer risk from wood smoke to be 12 times greater than from a similar amount of cigarette smoke.[3]

Wood smoke is actually the largest cause of particulate matter pollution in the Bay Area, accounting for up to half of the region's daily wintertime particulate pollution—more than diesel and industry sources.[2] A recent report from the Air District shows that fireplaces and woodstoves in the Bay Area are responsible for over 14 tons of fine particulate matter pollution (PM2.5) each winter day, compared to 7.3 tons from all the vehicle-related emissions and 4.9 tons from manufacturing and commercial activities.[4] Studies by the Air District indicate that wood smoke is responsible for one-third of the large particulate matter pollution (PM10) in the air basin during the winter months and two-thirds of the PM10 in Santa Rosa. Estimates for PM2.5 are much higher.[2]

The larger particles of soot and other carbon byproducts of wood combustion settle out of the air closer to the source, but the smaller particles tend to stay airborne for longer periods and over greater distances and can penetrate even weatherproofed doors and windows. Studies have shown that particle pollution levels inside homes can reach up to 70% of the pollution levels outdoors.[5]

On cold winter days (when people tend to burn wood), the air we breathe can quickly become unhealthy. Winter weather conditions create temperature inversions that put a lid over the lower atmosphere, trapping hazardous pollutants close to ground level. These in-

versions especially affect the valleys and canyon areas found throughout Sonoma County. Readings from air monitoring equipment in Santa Rosa have shown extremely high wintertime particulate levels, in large part due to the high number of wood stoves used to heat homes in that community.[2]

The Bay Area is currently considered to be out of attainment of the EPA's standards for particulate matter because of our wood-burning activities. To help our region attain the national standards, the Air Quality district operates a wintertime Spare the Air program to alert residents about conditions that are especially bad for burning wood (usually when the weather is expected to be cold and the air is stagnant). During these "No Burn Days," burning wood is illegal, and fines are issued for violations.

The EPA and the Air Quality district have only recently begun to address wood smoke pollution, but years of studies have linked wood smoke with a litany of health hazards. These include asthma attacks, diminished lung function, increased upper respiratory illnesses, heart attacks, and stroke. Long-term exposure to wood smoke has been linked to emphysema, chronic bronchitis, and arteriosclerosis; and laboratory studies have linked wood-smoke exposure to nasal, throat, lung, blood and lymph system cancers.[6]

In a laboratory study at Louisiana State University, researchers found that hazardous free radicals in wood smoke are chemically active 40 times longer than those from cigarette smoke—so once inhaled, wood smoke will harm the body far longer than cigarette smoke.[7] Other estimates suggest that a single fireplace operating for an hour and burning 10 pounds of wood will generate 4,300 times more carcinogenic polyaromatic hydrocarbons than 30 cigarettes.[8]

While pollution from wood burning is harmful to everyone, research has shown that it is particularly dangerous for children. Studies show that wood smoke interferes with normal lung development in infants and children and increases the risk of lower respiratory infections such as bronchitis and pneumonia.[9]

Wood smoke also affects our elderly residents. Studies overwhelmingly show that fine particulate pollution is a risk factor for heart attacks and death from strokes.[10] A 1994 report on the adverse effects of particulate air pollution reported a 1.4% increase in cardiovascular mortality for each 10 mg/m3 increase in particulate matter.[11] Newer research has confirmed that both short-term and chronic exposure to fine particle pollution, such as the kind produced by wood smoke, leads to increased respiratory illness and hospitalizations in people 65 and older.[12] New studies have also shown another threat produced by cigarette and wood smoke: isocyanic acid, which is known to be part of a biochemical pathway linked to inflammation, cataracts, heart disease and rheumatoid arthritis.[13]

According to the Air Quality district, researchers have not been able to identify a "no effects" threshold for particulate matter pollution. In other words, people exposed to particulate matter at levels below the current EPA standards may still experience negative health effects.[14]

Without fire, the human species would probably not have survived, and our civilizations could not have flourished. But the more we learn about the health impacts of wood burning, the more it seems obvious that we need to reduce wood smoke to improve our quality of life.

Like so many other "natural" things we've exposed ourselves to in the past—including tobacco smoke, asbestos and lead—it's time to acknowledge that wood smoke is a substance we can and should avoid. Physicians are urged to discuss wood burning with patients and their families, especially those that are most at risk, such as children, the elderly, and patients suffering from heart, lung and other ailments. ◇

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For more information and brochures about wood smoke, visit www.familiesforcleanair.org.

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The Meritage ACO

Mark Wexman, MD

Insurance companies routinely retain large portions of the premium dollar, even as government programs send medical facilities huge payments for hospitalizations, ancillary services and testing. Physicians often compete over the remaining crumbs. Few opportunities have arisen to change this medical funding paradigm—until now. The Affordable Care Act of 2010 opens a new pathway for partnership and alignment among doctors, hospitals and/or insurance companies for Medicare patients. That pathway is the Accountable Care Organization.

The promise of the ACO is the return of a "share of savings" from healthcare expenditures for Medicare patients to a local organization that can implement better healthcare and illness prevention strategies. The ACO is the legal vehicle that encourages clinically integrated physicians, hospitals and other providers to create and align clinical protocols for successful treatment and transition of patient care through the inpatient and outpatient environment. We can then share in the savings, if any, by demonstrating a reduction in the projected cost of care for a Medicare population.

The Meritage Medical Network (formerly known as the Marin-Sonoma IPA) has applied to be an ACO, and we expect to know before the end of the year if our application has been accepted. With the certainty of continued downward pressure on fee-for-service payments from Medicare (and thereby other insurers), if independent doctors, medical groups and hospitals are not in an ACO, there is no other mechanism for them to recoup the reduced reimbursement within the insurance system and maintain profitability.

Dr. Wexman, a Larkspur cardiologist, is managing partner of Cardiovascular Associates of Marin and chairman of the board for the Meritage Medical Network.

The Meritage Medical Network believes that developing an ACO should be central for independent physicians and hospital administrators as the key strategy for non-Kaiser patient care delivery. If we fail to implement an ACO in places like Marin, Sonoma and Napa counties, with all of their favorable health and economic attributes, then we deserve the cookie-cutter medicine likely to be imposed on us by far-away administrators and bureaucrats.

What does the structure of an ACO provide? It aligns the expense of an innovation in healthcare delivery with the economic incentive of better reimbursement for ACO providers who can demonstrate better care outcomes and patient satisfaction and "bend the cost curve." If we achieve the Three Aims stated in the ACO regulations—better care of individuals, better outcomes for populations, and lower growth in expenditures—then we share in dollars not expended on unnecessary care.

An ACO congestive heart failure care program, for example, would focus on keeping patients well and out of the hospital. CHF is a significant example because it is a high frequency illness, with great monetary cost and quality of life lost. What does it take to create better managed, less expensive CHF patients? The answer includes (1) intensively managed in-hospital treatment with collaboration between cardiologists and hospitalists or internists treating the acute illness, and (2) a combined group of mid-level providers (nurses, discharge planners and pharmacy technicians) to facilitate triage and to communicate with primary and specialty physicians. Such communications will allow for prompt follow-up after discharge. Rapidly adjusting patient medicines and following best-practice protocols for optimal prognosis will reduce readmissions.

So why aren't these procedures in place today? Because the savings accrue to the insurer or the government payer, leaving hospitals and physicians with only the expenses and "heaven points" earned for doing the right thing. For our hospital partners, the scary thing about the new ACO paradigm is that keeping patients out of the hospital is counter-intuitive to their longstanding financial planning of "filling beds with heads." Now our hospital partners will focus on better-managed patients and fewer recurrent and total admissions. Hospital profitability will depend on a share of the accumulated savings from bending the cost curve. The current ACO model

will be protected from downside risk for three years, as systems are put in place and experience is gained.

How do Medicare patients enroll in an ACO? They are attributed to the primary care physician with whom they have had most of their visits that year. How do primary care physicians, specialists and hospitals begin to participate in this new system? Primary care physicians can belong to only one ACO, but specialists can see patients from multiple ACOs, if they choose. Physicians can enroll in an ACO voluntarily by agreeing to share information and participate in clinical protocols. Patients are not limited in any fashion as to whether they can get healthcare in or out of the ACO.

The Medicare population in Marin, Sonoma and Napa counties is about 136,000 people, 45% of whom are already covered by Kaiser. That leaves about 75,000 Medicare recipients in our practices for a potential network. If we can change the inflation on medical cost from the 8% predicted to 4% actual, then half of the savings (2%) can be used for reinvestment in our community medical care processes and for additional hospital and physician reimbursement. How much money are we talking about for such small changes in the inflation of cost of care? The average Medicare patient uses about $12,000 per year in services, so total spending on the non-Kaiser group in Marin, Sonoma and Napa counties is about $900 million per year. The 8% expected inflation rate for that amount is $72 million per year, so if we reduce the inflation to 4%, we would organizationally share $18 million per year.

How does the Meritage ACO allow a change in the relationship of medical groups and hospitals with the large PPO insurers? As a clinically integrated group with an ACO designation, we can negotiate together and offer the programs and processes that were originally designed and demonstrated in our Medicare patients to these commercial insurers. In turn, when we have an effect on the health costs of the population under management, we negotiate for a portion of the savings to return to the ACO members. Several PPO insurers have already stepped forward to underwrite the start-up costs of a PPO-ACO structure with their partner medical groups.

Doing nothing and waiting for the inevitable forces of healthcare economics to negatively affect the quality and value of medical practice is healthcare suicide. Although we cannot know the outcome of our investments in this ACO strategy in advance, we can be confident that we are using the best legal structure available to create a better program for healthcare delivery in our counties than anyone in Washington or Sacramento is likely to propose. No waiting on the sidelines on this one: we must all step up and be held accountable to the current and next generation of physicians and to the communities that we serve. ◇

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ACO Resources from CMA

The CMA website at **www.cmanet.org** offers a wealth of materials about ACOs and other aspects of the Affordable Care Act. Among the latest offerings:

Legal and Practical Considerations Concerning Accountable Care Organizations (CMA On-Call document #201). Provides a general overview of ACOs and the legal and practical issues that physicians should consider when vetting ACOs.

Accountable Care Organizations and Medical Foundations (Powerpoint presentation). CMA General Counsel Francisco Silva outlines the requirements of the ACO and 1206(l) medical foundation laws and identifies risks and benefits that physicians should consider.

FAQs About Accountable Care Organizations (Patient handout). Handout for patients that explains their rights in relation to ACOs.

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Tips for Successful Implementation of EHRs

Dawniela Hightower

Implementing an electronic health record (EHR) can be either a mildly painful process or a nearly excruciating one. The dividing line—according to Bre Jackson of the California Health Information Partnership & Services Organization—is between physicians who heed the advice of experts and make important choices in the earliest stages of their implementation and those who don't. "That is a sweeping statement," she says, "but it bears a lot of truth." As chief information officer of CalHIPSO, the country's largest regional extension center, Jackson is responsible for ensuring that over 6,000 California physicians have successful EHR installations.

Dr. Steven Vargas would likely agree with Jackson's assessment. A family physician at a small private practice in Healdsburg, Vargas describes his conversion from paper to EHR as a smooth process. That's not to say the transition didn't impact his practice or that it didn't cause a slowdown in patient volume—because it did. But the anticipation of those outcomes motivated Vargas to set a course that had his practice functioning at pre-installation volumes more quickly than most.

Vargas attributes this achievement primarily to staff preparedness and says that the single biggest secret to success was getting staff to buy in fully and early. He included his entire team in the discussion over which EHR to implement, and kept them informed of the progress every step of the way. Realizing that implementation was going to be disruptive to the daily work of his support staff, Vargas knew that his best chance of success and peace of mind was to have every staff member on board and in support of the change. A successful EHR adoption can't be imposed upon staff—adoption must be made through teamwork.

When asked what drove him toward an EHR, Vargas notes, "I decided to implement once I found the right product," and adds that he waited on the sidelines of the industry for several years, observing and learning from the actions of his peers. He kept close watch on the products that were entering and leaving the market, wanting to ensure that his EHR company would be around for the long haul. "I asked for references," he recalls, "and called current customers of each product I was considering." Vargas warns that if the company can't provide current customer references, its system is likely not worth considering. He made his final selection after discussing the products with colleagues, narrowing down his lists to just a few, and downloading their online demos.

Vargas's experience is one that CalHIPSO would like to replicate in medical practices around the state, both in terms of outcome and timeline. With that goal in mind, Jackson shares the following set of EHR adoption tips when she makes presentations to physicians.

Do your homework. It's important that you enter into the vendor selection process with a clearly defined set of needs. Ask yourself which EHR functions support quality patient care while simultaneously meeting the needs of your business. Determine which features are required to meet the "meaningful use" measures or other quality reporting incentives. Then make a priority list, understanding that the entire list might not fit into the budget. Reading neutral third-party reports can help balance the sometimes partial opinions of colleagues.

Understand the costs. Adopting an EHR could require significant outlays of funds, including supplemental investments in hardware, software, training and future maintenance fees. A handful of products on the market have reduced the financial barrier to entry by offering low initial investments. Some of these products, however, impose a long list of additional fees for upgrades, new service modules, data protection and ongoing training. With other products, cost savings can result in loss of control over patient data. Paying close attention to contract terms is extremely important, says Jackson. "Work with your regional extension center," she suggests.

Ms. Hightower is the marketing and communications manager for CalHIPSO.

"We've spent hundreds of hours negotiating favorable vendor contract terms with EHR vendors, and we make these contracts available to any provider who enrolls with us."

Physicians are not required to sign CalHIPSO's EHR vendor contracts to take advantage of the regional extension services. Vargas, for example, joined CalHIPSO after selecting his EHR. Even though he chose a product outside CalHIPSO's contract program, he was still able to receive subsidized technical services from CalHIPSO throughout his implementation. He received these services through the Redwood Community Health Network (RCHN), one of CalHIPSO's 10 local extension centers throughout the state. RCHN contracted with a product specialist of Vargas's choice to come into his office and assist with implementation.

Have an onsite champion. An onsite champion is a staff member, not a physician, who is enthusiastic and supportive of the project and willing to take a leadership role in getting the rest of the staff on board. Physicians can spur the development of an onsite champion by mirroring Vargas's technique of involving staff in the entire selection and adoption process. "Staff involvement is critical," observes Jackson. "The practice manager plays an instrumental role in developing workflows to increase technology adoption, direct patient awareness and reduce the feeling that an EHR is disruptive. A motivated and informed practice manager will keep the wheels on the project moving positively forward."

Invest in training. It's easy for some physicians to write off additional training as an unnecessary expense, especially considering that time spent training is time spent not seeing patients. But the omission of training will cost more in the long run, both in time and money. Patient volumes will never reach capacity while staff members are trying to fumble their way through a new EHR. "A solid EHR training plan will help clinicians make the transition from paper to electronic health records," says Jackson. "Providing staff just-in-time training will reduce bottlenecks and increase morale. While training provided by the EHR vendor is important, it is unlikely to be sufficient."

Solve workflow solutions as a team. Involving the staff in all workflow changes goes back to Vargas's suggestion that a successful adoption requires teamwork. The team approach recognizes each staff member's role in delivering care. The approach demonstrates that all roles, both large and small, affect the office function, and that adopting an EHR requires a complete functional shift. While workflow outcomes will be unique to each office, the process of developing a new workflow should allow for the contribution of every player.

Plan, prepare, and expect the unexpected. One important piece of advice that Vargas offers is to have flexibility around the go-live date. This flexibility was especially critical for Vargas's practice because he opted to go live with all patients, all at once. To accomplish this feat, he assembled a practice lab with computer stations in his back office. "I would shut down my office for two hours a day, and not see any patients," he recalls. Vargas's team spent one or two days a week running real-life scenarios through the EHR practice lab. As the go-live date came near, the team didn't feel ready yet, so they returned to the practice lab to run more scenarios.

Vargas also hired temporary help to enter patient demographics. He considers this to be one of the best and least expensive investments of the project. "I didn't want to burn out my staff with hours of data entry," he says. Instead, he hired college students with strong typing skills to enter non-medical data. This low-cost solution helped keep his team fresh and motivated.

Notifying patients is an often overlooked step in the EHR implementation process. Patients who aren't notified can be left wondering if their physician's level of service is declining. Jackson says that once patients know their provider is transitioning to EHRs, they are more often than not pleased and accept the temporary reduction in patient volume.

Electronic health records are tools to help physicians succeed at their mission of providing quality patient care. Implementing an EHR will prompt discussions about best practices, practice performance and management of clinical data. As a result, the EHR adoption roadmap should reflect known wins that will affect every aspect of the practice, far beyond the technology itself. A strategic approach to EHR adoption can turn those changes into opportunities for improvement, while helping physicians assuage the apprehension that always accompanies change. ◇

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About CalHIPSO

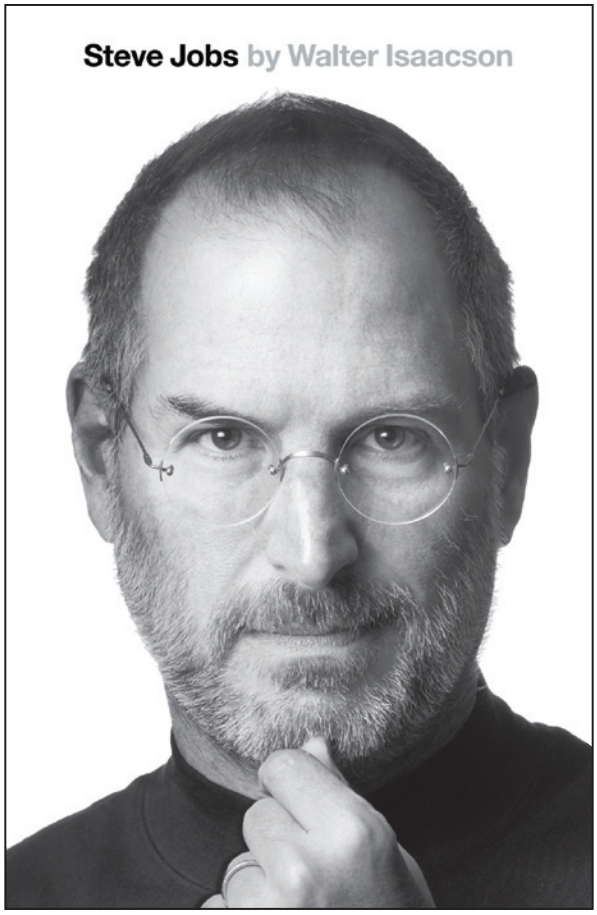
CalHIPSO is a not-for-profit joint venture between the California Medical Association, the California Primary Care Association, and the California Association of Public Hospitals and Health Systems. As one of 62 federally designated Regional Extension Centers, CalHIPSO helps providers in California navigate the complicated world of electronic health record adoption. As of spring 2012, more than 7,700 providers are members of CalHIPSO and are ready to adopt EHRs and demonstrate Meaningful Use of an EHR in order to qualify for federal incentive payments under the American Recovery and Reinvestment Act stimulus program.

CalHIPSO is the largest Regional Extension Center in the country. Serving 56 of California's 58 counties, CalHIPSO's market stretches across the state in both urban and rural areas. CalHIPSO's target providers work in community clinics, rural hospitals and clinics, small and solo private practices, and public hospitals.

For more information about CalHIPSO, visit www.calhipso.org.

A Tale of Two Steves

Rick Flinders, MD



Steve Jobs, by Walter Isaacson, Simon & Schuster, 656 pages.

Perhaps the first clue to how much Steve Jobs thought of himself is his choice of biographer: Walter Isaacson, the same man who wrote biographies of Albert Einstein and Benjamin Franklin. Did Jobs consider himself in the same league, innovatively and historically, as these two? Yes, he almost certainly did. Perhaps the ultimate measure of his grandiose audacity is that he was probably right.

Few individuals have altered and shaped the fabric of our daily lives more than Steve Jobs. We're talking here of an impact on the scale of people like Thomas Edison and Henry Ford. Look around and you'll see, within arm's reach, products of his creation that literally touch everything we do. The laptop. The cell phone. How we listen to music. How we communicate.

Jobs didn't do this alone. But as he stood at the convergence of information technology and the creative arts, during an historic moment as transformative as the industrial revolution, he more than any other gave expression to the products of information technology that have become embedded into our daily lives.

How did he do this? And who was the man who did it? The answers, as revealed in Abramson's biography through hundreds of hours of interviews with the people who knew him, are predictably complicated.

Jobs had a ferocious, even obsessive, will that could drive him to the exclusion of everything else, including reality. Those who worked with him all speak familiarly of what came to be called "Steve's reality distortion field." Often if a fact or situation interfered with his vision, he simply wouldn't acknowledge its existence. This became a double-edged sword. On the one hand it led him to achievements others in the industry considered "impossible," such as wresting control of recorded music from Sony and repackaging it as iTunes. On the other, it allowed him to deny and virtually abandon his daughter born in 1978, curious behavior for a father who resented his own biological parents for putting him up for adoption at birth.

As with most genius, there comes idiosyncrasy. Jobs' creations all bore the same signature characteristics. They were elegant, durable and extraordinarily functional. But he went beyond that. They had to be aesthetically pleasing inside the locked compartments that were never visible to consumers. Even the machinery with which they were manufactured had to be of a certain color and decor.

Every Apple product is packaged and shipped in a way that controls the experience of the customer who opens it. This control may enhance market value or brand loyalty, but Jobs' obsti-

Dr. Flinders, a hospitalist who teaches in the Santa Rosa Family Medicine Residency, serves on the SCMA Editorial Board.

nacy could drive up costs and notoriously delay critical release of products. He once defended his disdain of focus groups by saying they were irrelevant: "People don't really know what they want until I show them."

The mark of Jobs' personality persists in all his creations. Every Apple product is a "closed system." No hardware may be added. No screwdriver can take it apart. Certainly we've all experienced the paranoid possessiveness with which Apple guards its products, copyrights and use agreements. To market an e-book on Amazon Kindle, for example, recently took me a couple of days. To post the same work on Apple's iBooks took weeks.

To work for Jobs was a mixed blessing. At meetings he could rant, cry, berate and belittle employees publicly, sometimes all at once. His intensity was legendary. He would sometimes hold a person in an unnerving gaze, without blinking, for several minutes at a time. To employees he was often not merely rude or dismissive, but cruel. Curiously, he carried Yogananda's *Autobiography of a Yogi* with him most of the time, and he reread the book once a year. It is said, by those who knew Yogananda, that he could enter a room and fill it with calm. It is also said, by those who knew Jobs, that he could enter a room and fill it with ego.

And yet, those who did work for Jobs are in almost unanimous agreement: "Without Steve we could never have risen to our best work, and would have never accomplished what we did." For me, a baby boomer, the book is not just the story of a fascinating contemporary, but a fascinating story of our contemporary history.

My favorite parts are of the early Steve Jobs. While seniors in high school, Jobs and his wonk friend Steve Wozniak posted computer-generated banners all over campus one afternoon saying, "Remember: Tomorrow is Bring-Your-Pet-to-School Day." The following day such a menagerie of diverse and squabbling creatures descended on the unsuspecting campus that classes were cancelled, students sent home, and Jobs and Wozniak were suspended.

The two became inseparable. As Jobs recalls, Wozniak was "the first guy I ever met who knew more electronics than me." Their first collaboration was the Blue Box, a device that replicated the tones that routed signals on the entire AT&T network, and allowed users to make long-distance calls anywhere in the world for free. The two friends once called the Vatican from a phone booth. Wozniak pretended to be Henry Kissinger and asked to speak to the pope. What began as pranks, however, became the template for an enduring partnership. Wozniak was the gentle wizard, coming up with inventions he was happy to give away. Jobs would figure out how to make them into a user-friendly package, market them, and make millions.

Jobs attended Reed College in Portland. He dropped out during the first semester, but he remained there for the next 18 months, auditing courses in Japanese calligraphy and Zen meditation. It was there that he acquired the aesthetic style that shaped all his future creations. The multiple fonts that were part of the graphic interface for the very first Apple computers, for example, Jobs attributes directly to his studies and experiences in Portland. The fonts became standard in the industry.

I find an inherent irony in Jobs' life and legacy. He was a Zen Buddhist, dedicated to the philosophy and practice of being fully focused in the ever-present moment of here and now. The irony is that he created a technology that virtually guarantees nearly constant distraction in the hands and ears and lives of an entire generation. The average 20-year-old checks his or her handheld device for new messages every 27 seconds. Watch a group of high school students at a table in Starbucks "engaged" in conversation, for example, and see how often their eyes and attention are diverted from the one who is speaking to the palms of their hands.

How many young people are attuned to the sounds of their immediate environs or the world around them? Compare this group to the number sealed off from the world by earphones, and carried by sound to anywhere but the here and now. I was recently blindsided by a young cyclist who turned, not in front of my car, but into my car. As he bounced off my passenger side door and sped away, I noticed the signature white earplugs that rendered him oblivious to surrounding traffic and the rest of the world.

Perhaps the ultimate key to the man who exploded the dawn of the personal computer is revealed in the interview Abramson has with Jobs near the final days of his life. They sat and chatted in Jobs' living room for most of the day, and listened to music from Jobs' own playlist. Other than Bach's second Brandenburg Concerto, the playlist was almost entirely Dylan, the Beatles, some early Rolling Stones. When Abramson noted this, Jobs smiled and said, "I grew up in the seventies, but my heart was in the sixties."

Bono of U2 has said of Jobs: "The people who invented the 21st century were sandal-wearing hippies from the West Coast like Steve, because they saw differently. The sixties produced an anarchic mindset that is great for imagining a world not yet in existence."

Here's a guy who goes to Reed College, drops out, takes LSD, studies calligraphy, travels to India, practices Zen, and then returns to the Bay Area to found a company that revolutionizes the practical use of information technology and becomes the richest company in the world. Ultimate poster child of the sixties?

To Steve the genius, I say, "Kudos. You were a master at putting together ideas, art and technology in ways that invented the future. You were living proof of your own motto: The people who are crazy enough to think they can change the world are the ones who do."

To Steve the jerk, I say, "Why'd you have to be so mean?" ◇

Email: flinder@sutterhealth.org

NEW MEMBERS

Jennifer Betts, MD, Family Medicine*, 144 Stony Point Rd., Santa Rosa, 521-4500, Univ Health Sciences 1997

Michael Caccavale, MD, Diagnostic Radiology*, Vascular & Interventional Radiology*, 121 Sotoyome St., Santa Rosa, 546-4062, Univ Arizona 2006

Wynnelena Canio, MD, Internal Medicine, Psychiatry, Geriatric Medicine, 401 Bicentennial Way, MOBE 2nd floor #270, Santa Rosa, 393-3274, Ross Univ 2006

Carolyn Cole, MD, Emergency Medicine, 401 Bicentennial Way, Santa Rosa, 393-4800, SUNY Brooklyn 2008

Henry Flores, MD, Surgery*, *General Surgery,* 401 Bicentennial Way, Santa Rosa, 393-4090, Univ Minnesota 1994

Shawn Hsieh, MD, Physical Medicine & Rehabilitation*, Sports Medicine*, 3975 Old Redwood Hwy. MOB 5, #152, Santa Rosa, 566-5557, St. Louis Univ 2007

Patricia May, MD, Surgery*, Hospice & Palliative Medicine*, 401 Bicentennial Way, Santa Rosa, 393-3251, Chicago Med Sch 1990

Afshin Mohammadi, MD, Neurology*, 401 Bicentennial Way, Santa Rosa, 571-3923, Shiraz Univ 2000

Roxanne Rapan, MD, Anesthesiology, 401 Bicentennial Way, Santa Rosa, 393-4000, Mount Sinai Med Sch 2004

Anish Shah, MD, Psychiatry, 1049 4th St. #G, Santa Rosa, 206-7268, Sardar Patel Univ 1996

Brian Vukelic, MD, Family Medicine*, 401 Bicentennial Way, Santa Rosa, 393-4000, Univ Washington 2009

* = board certified
italics = special medical interest

Note: SCMA is pleased to welcome all the resident physicians at the Santa Rosa Family Medicine Residency as members of SCMA and CMA. The residency achieved 100% participation due to the efforts of Program Director Dr. Jeff Haney, Deputy Director Dr. Walter Mills, and Dr. Anthony Lim. SCMA thanks the residency program for its support of organized medicine.

Katya Adachi, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, UC San Francisco 2011

Nicole Baltrushes, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Univ Chicago 2012

Allison Block, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, UC San Francisco 2011

Anna Chollet, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Tulane Univ 2012

Cathryn Christensen, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Harvard Med Sch 2010

MaryAnn Dakkak, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, UC San Francisco 2012

Parker Duncan, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, UC Irvine 2010

Yael Eskinazi, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Univ Maryland 2011

Adam Francis, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, UC Irvine 2011

Jared Garrison-Jakel, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, UC Irvine 2010

Hana Grobel, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Mount Sinai Sch Med 2010

Tyler Gray, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Columbia Univ 2012

Aaron Greenblatt, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Univ Pennsylvania 2011

Karl Greer, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Univ Texas 2012

Ann Griego, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, UC San Francisco 2011

Sarah Junker, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Univ Colorado 2012

Scott Karpowicz, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Georgetown Univ 2011

Ember Keighley, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Univ Michigan 2011

Jennifer King, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, UC San Francisco 2011

Molly Kirkconnell, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, UC Davis 2012

Amy Marietta, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Univ North Carolina 2012

Laura Martin, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Boston Univ 2010

Trevor Moerkerke, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, UC San Francisco 2011

Ron Romero, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Univ Michigan 2012

Emily Shaw, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Brown Univ 2010

M. Jasmine Silva, DO, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Western Univ 2012

Noreen Singh, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Yale Univ 2012

David Stromberg, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Univ New Mexico 2010

Arlene Vazquez, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, UC San Francisco 2012

Trang Vo, DO, Family Medicine, 3569 Round Barn Cir., Santa Rosa, 303-3600, Touro Univ 2010

Alliance Donates Computers to Foster Grads

For foster children, high school graduation literally means "emancipation," as they move out of the foster system and into the world. But it's emancipation with an asterisk, because their state funding is limited. While other high school graduates head off to college with parental support, foster graduates often have to fend for themselves.

In 2007, the SCMA Alliance—which has a long history of supporting foster children through its Give-a-Gift program—began helping foster graduates meet their college expenses by giving them laptop computers. The program has grown since then, and this year the Alliance raised enough money ($17,300) to buy more than 20 laptops for local foster graduates.

Roberto Alvarez, Brenda Carrillo and Drew Howell are among the foster graduates who received laptops from the SCMA Alliance at an Aug. 15 ceremony at Santa Rosa Junior College. "You guys are really awesome for what you provided for us," said Howell. "We're very grateful." He will be attending SRJC this fall, along with Alvarez and Carrillo. All three plan on transferring to UC Berkeley or other universities when they finish at the JC.

"There are people out there who care about you being successful," said SCMA Alliance member Lindsay Mazur, who addressed the crowd of about 30 foster students and teachers at the beginning of the ceremony. Alliance members Kathryn Koh, Carol Lynn Wood, Shawn Devlin and Laura Robertson also attended the event.

Brenda Carrillo was especially grateful for her laptop. "I hope you do it for more youth," she said. "Right now the economy is kind of backward. We really need the help."

To contribute to the Give-a-Gift program, visit the SCMA Alliance website at www.scmaa.org or send an email to giveagiftteam@yahoo.com. ■

Foster graduates (left to right) Roberto Alvarez, Brenda Carrillo and Drew Howell with their new laptop computers at the SRJC ceremony.

SCMA Alliance members attending the SRJC ceremony included (left to right) Kathryn Koh, Carol Lynn Wood, Shawn Devlin, Laura Robertson and Lindsay Mazur.

Improving Physician Well-Being

Walt Mills, MD

As physicians, we're familiar with anxiety. We have survived the anxieties of premed, medical school and residency. We step into our work every day, knowing there may be an error, something may go wrong, quality may be affected. If you're practicing in one of the new models of care, there's the additional anxiety brought on by asynchronous care with secure emails, telemedicine, perhaps patient texting and voice messages. And have you googled yourself lately, or seen what they are saying about you on Twitter or blogs? Transparency has put you in Yelp, with patient commentaries for all to see.

Many studies have shown that physician stress, fatigue, burnout and depression negatively affect patient care. Excessive workloads and restricted autonomy lead to stress and burnout. The physician suicide rate is six times higher than the general population, their cardiovascular mortality rate is higher, and their lifetime risk for chemical dependency is one in 10. These rates are almost certain to increase as health reform is implemented during the next few years.

One of the core elements of health reform is the so-called "triple aim" of better health, better health care, and lower per capita costs.[1] We propose adding a fourth aim to this list: physician well-being.

How can physicians achieve well-being? We can use evidence-based strategies to adapt and manage our anxieties, and we can choose our attitude independent of circumstance. Evidence shows that mindful communication programs can improve physician well-being and reduce burnout, depression and anxiety.[2]

Self-awareness seems to be key. We regularly ignore indicators of distress, both in ourselves and in our colleagues. As noted in a recent *Lancet* article, the ideals of self-reliance, independent judgment and self-sacrifice inculcate notions that the best doctors have few needs, make no mistakes, and are never ill.[3]

SCMA and other organizations respect the growing evidence that poor physician well-being negatively affects efficiency, workplace productivity, and recruitment and retention. Most notable is that our distress compromises quality and patient safety—the very point of health reform!

Five years ago, SCMA designed a strategic plan to improve physician well-being and the health of our community. We advocated in Sacramento and Washington DC for payment reform, improved patient access, and other measures to protect our members and the patients we serve. We partnered with the county health department, the family medicine residency, community health centers, hospitals and medical groups to support medical student and residency education aligned with workforce development. We convened conversations to improve specialty access for our safety-net patients.

Our board of directors will soon be asking for input from physicians to design a new five-year plan to serve our members, focusing on systemic means to obtain that fourth aim, physician well-being. At a minimum, for the large healthcare institutions in which most of us now or will soon practice, we will highlight the strategic importance of supporting physician well-being. Potential means of doing so include measuring physician wellness as an indicator of health-system quality, and gathering evidence on how to intervene if suboptimum system performance is identified. Sonoma Health Action is developing a community health dashboard: Why not include physician well-being?

As 21st century physicians, we must artfully blend Marcus Welby and Steve Jobs. No matter how well we balance the talents these characters personify, if we are "sick," we will fall short of providing the care our patients deserve. We must ask ourselves if we would want our family and those we love to be cared for by a burned-out, fatigued and depressed colleague.

If done well, this well-being initiative is a "win" for all—physicians, patients and the healthcare system. Promoting dialog among key community stakeholders about physician well-being may be too bold. But knowing what we know about the inevitable suffering that comes from unaddressed anxiety, how can we not try?

Please send me your thoughts. We will be soliciting yours! ◇

Email: walter.w.mills@kp.org

Dr. Mills, a family physician at Kaiser Santa Rosa, is president of SCMA.

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* Physicians Insurers Association of America Risk Management Review: 2011 Edition.

**Jena et al. Research Letter, Online First: Outcomes of Medical Malpractice Litigation Against U.S. Physicians. *Archives of Internal Medicine*. May 14, 2012.

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